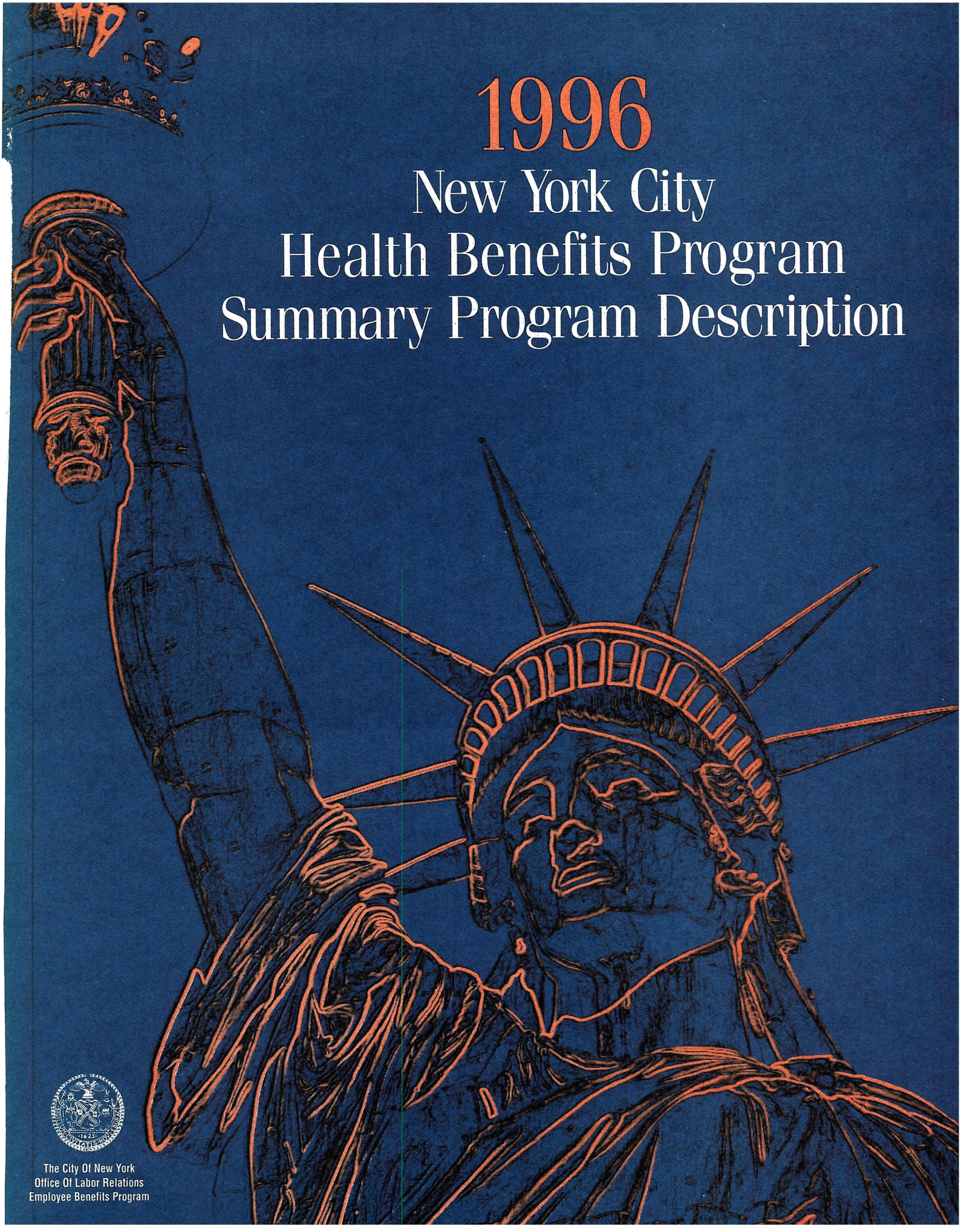
1996

New York City Health Benefits Program Summary Program Description



The City Of New York
Office Of Labor Relations
Employee Benefits Program

THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

October 1995

Dear Fellow City Employee:

With dramatic and sweeping changes reshaping the economic realities of life in our city, the City of New York and the Municipal Unions, in a cooperative effort, are continually seeking new and creative responses. The labor agreement reached at mid-year was one such response which all parties can look upon with pride.

As part of that pact, we ratified our commitment to continue providing the best affordable, comprehensive health care coverage to all of our employees, retirees and their families. The health plan choices and benefit packages presented in this booklet follow from that commitment.

While many employers in the private sector narrow the health insurance choices available to their employees and shift a significant portion of the cost to them, almost all of our employees will continue to have several options and the majority will make no contributions toward the cost of their basic health insurance coverage. Retirees, in many instances, will now have more enrollment opportunities - and at no cost to them - than ever before. Frankly, I'm proud of this.

Please read the booklet carefully before choosing your plan. Select the one which best meets your needs. Then refer to the booklet whenever you need information about your coverage. It's important that you understand your benefits before you need to use them.

"The health of employees, retirees, and their families has always been, and will continue to be, very important to the City of New York". I said this to you last year. I say it with no less resolve in 1995!

Sincerely,

Rudolph W. Giuliani
Mayor

TABLE OF CONTENTS

INTRODUCTION

Through collective bargaining agreements, the City of New York and the Municipal Unions have cooperated in choosing health plans and designing the benefits for the City's Health Benefits Program. These benefits are intended to provide you with the fullest possible protection that can be purchased with the available funding.

This "Summary Program Description" booklet gives brief plan descriptions and a comparison of benefits of all available plans. It also provides important information about the Health Benefits Program. You will receive an in-depth description of the plan you have chosen from your health plan when you enroll.

The Fall 1995 Transfer Period will take place from October 2 to October 31, 1995, and will be open to EMPLOYEES ONLY. Retirees cannot transfer during this Transfer Period, but may transfer in the fall of 1996 or use the Once-In-A-Lifetime Transfer Opportunity.

All employee transfer applications must be submitted by October 31, 1995.

CHOOSING A HEALTH PLAN

To select a health plan that best meets your needs, you should consider at least four factors . . .

COVERAGE . . .

The services covered by the plans differ. For example, some provide preventive services while others do not cover them at all; some plans cover routine podiatric (foot) care, while others do not.

CHOICE OF DOCTOR . . .

Some plans provide partial reimbursement when non-participating providers are used. Other plans only pay for or allow the use of participating providers.

CONVENIENCE OF ACCESS . . .

Certain plans may have participating providers or centers that are more convenient to your home or workplace. You should consider the location of physicians' offices and hospital affiliations.

COST . . .

Some plans require payroll and pension deductions for basic coverage. The cost of the Optional Riders also differs. These costs are compared on charts in Section Five of this booklet. Some plans require a copayment for each routine doctor visit. Some plans require you to pay a yearly deductible and coinsurance before the plans will reimburse you for the use of non-participating providers. If a plan does not cover certain types of services that you expect to use, you must also consider the out-of-pocket cost of these services.

FOR FURTHER INFORMATION ON . . .

— benefits
— participating doctors
— office locations, etc.,

call the plans you are interested in directly. Telephone numbers and addresses are listed at the end of each plan description.

SECTION ONE

IF YOU NEED ASSISTANCE

Retirees

Retirees with questions about benefits, services, or claims should write or call their health plan at the address given either in this booklet or the appropriate plan booklet. When writing to the plan, give your Social Security number, certificate number (if different), group number, name and address. The Health Benefits Program is also available to provide service and information to City retirees who have questions about or problems with their health benefits or pension check deductions. Retirees writing to the Health Benefits Program should always include the following information:

— Name (Please Print)
— Telephone Number
— Social Security Number
— Pension Number/Retirement System
— Name of the City agency from which you retired
— Your last Civil Service title/title code number
— The name of your union or welfare fund (if any)
— Health code and the amount currently being deducted from your pension check
— Date of Retirement

Retirees can contact the Health Benefits Program at:

City of New York Health Benefits Program
40 Rector Street - 3rd Floor
New York, NY 10006
(212) 513-0470

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Employees

Employees should direct questions concerning the Transfer Period, enrollment, eligibility or paycheck deductions to, or obtain application forms (ERB 95) from their worksite agency personnel or payroll office. Employees with questions relating to benefits, services, or claims should write or call their health plan at the address given in either this booklet or the appropriate plan booklet. When writing to a health plan, give your Social Security number, certificate number (if different), group number, name and address, date(s) of service, and claim number(s), if applicable.

SECTION TWO

EMPLOYEE ASSISTANCE PROGRAMS (EAP)

The City of New York's Employee Assistance Programs (EAPs) are staffed by professional counselors who can help employees and their eligible dependents handle problems in areas such as stress, alcoholism, drug abuse, mental health, and family difficulties. An EAP will provide education, information, counseling and individualized referrals to assist with a wide range of personal or social problems. If you don't have an EAP in your own agency or union, you can get help at the New York City Employee Assistance Program (listed below).

The New York City Employee Assistance Program gives you free, personal and quick access to referrals for professional help. An employee's contact with this service is private, privileged and strictly confidential. No information will be shared with anyone at any time without your written consent.

Employees of the Police and Correction Departments should contact their agencies' EAPs for appropriate case review, referral, and follow-up. Employees of the Police and Correction Departments and those in the Probation Officer title series cannot use their agencies' EAPs or the New York City EAP if they wish to use the substance abuse treatment services, but instead may self-refer to their health plan.

City of New York

Employee Assistance Programs

Bronx Municipal Hospital
Employee Assistance Program
(718) 918-7101

Central Labor Rehabilitation
Council of New York
(212) 532-7575

Correction, Department of
Employee Assistance Program
(212) 487-7451, 52

DC-37 Health and Security
Personal Service Unit
(212) 815-1250

Elmhurst Hospital Center
Employee Assistance Program
(718) 334-4000

Fire Department
Employee Assistance Program
(212) 570-1693

Health and Hospitals Corporation
Employee Assistance Program
(Central Office, EMS)
(212) 840-5259

Housing Authority
Employee Assistance Program
(212) 306-4455 or 56

Hunter College
Employee Assistance Program
(212) 772-4051

Metropolitan Hospital Center
Employee Assistance Program
(212) 423-7657

New York City
Employee Assistance Program
(212) 306-7660

Police Department
Counseling Service
(212) 489-0585

Sanitation, Department of
Employee Assistance Unit
(212) 431-2560

SECTION THREE

SUMMARY DESCRIPTION OF HEALTH PLANS

Summaries of the benefits of the available health plans appear on the pages that follow. The plans have been divided into three sections: Health Maintenance Organizations (HMOs), Point-of-Service Plans (POS) and Participating Provider Organizations (PPO)/Indemnity Plans, and Health Plans for Medicare Enrollees.

The health plan descriptions and comparison charts contained in this booklet are for informational purposes only. The benefits are subject to the terms, conditions and limitations of the applicable contracts and laws.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

(For Employees and Non-Medicare Retirees and their dependents)

A Health Maintenance Organization (HMO) is a system of health care that provides managed, pre-paid hospital and medical services to its members. An HMO member chooses a Primary Care Physician (PCP) from within the HMO network, and the PCP manages all medical services, provides referrals, and is responsible for non-emergency admissions. Individuals and/or families who choose to join an HMO can receive health care at little or no out-of-pocket cost provided they use the HMO's doctors and facilities. Because the HMO provides all necessary services, there are no deductibles to meet or claim forms to file. In most plans, if a physician outside of the health plan is used without a referral from the PCP, the patient is responsible for all bills incurred.

Recent Benefit Changes

Effective July 1, 1995

- **HIP/HMO** has expanded its service area to include Rockland and Orange counties. Medical services are provided by HIP Network affiliated physicians practicing in their own offices. Primary Care Physicians must call HIP for preauthorization prior to inpatient admission to a hospital, hospice or skilled nursing facility. HIP of New Jersey has expanded its service area to include Atlantic, Hunterdon, Morris, Monmouth, Ocean and Salem counties.
- **MetroPlus Health Plan** (formerly Metropolitan Health Plan) has expanded its service area to include the north Bronx.
- **U.S. Healthcare HMO** has increased its copayment for physicians' office visits from $2 to $5. Emergency room copayment has increased from $15 to $35 and all mental health visits now cost $25 per visit. A $5 copayment is also required for each referred visit to a participating specialist. U.S. Healthcare HMO has expanded its service area to include Dutchess, Sullivan, and Ulster counties in New York, as well as the metropolitan area of Atlanta, Georgia, the entire state of Rhode Island, and several counties in Virginia.

Effective January 1, 1996

- **Physicians Health Services** will expand its service area to include Bronx, Brooklyn, Queens, Manhattan, Staten Island, Nassau and Suffolk counties. The optional rider for prescription drugs will be increased from a $2000 maximum to unlimited prescription coverage.
- **WellCare** will expand its service area to include Brooklyn, Broome, Bronx, Fulton, Manhattan, Montgomery, Otsego, Queens, Schoharie and Westchester counties in New York. WellCare coverage will include chiropractic therapy, nutritional counseling, and acupuncture. WellCare will institute a $5 copay for all office visits and diagnostic testing.

Special Notes

- Employee and Non-Medicare Retiree premium costs for each HMO are listed on pages 50 and 51.
- For Medicare-eligible retirees and their Medicare-eligible dependents, these health plans provide benefits similar to those described in each summary. For information about Medicare enrollee coverage, please refer to the health plans in Section Three III on pages 24 through 33.

ChoiceCare

ChoiceCare offers New York City employees and retirees an opportunity to access quality health care in **Queens, Nassau and Suffolk counties**. More than 2,500 private practice physicians and providers participate in the tri-county service area. Each of ChoiceCare's providers has been carefully selected to meet the highest standards of care. Through a strict credentialing process and an ongoing quality assurance program, ChoiceCare ensures that members receive the best medical care available.

At the heart of ChoiceCare's health care plan is your Primary Care Physician (PCP). This is a Family Practitioner or Internist or in the case of children, a Pediatrician which you select from our extensive medical directory. Your Primary Care Physician, or "PCP", coordinates all your health care needs. This includes providing routine care, prescribing medication, arranging for referrals to specialists, laboratory tests, X-rays and hospital stays when necessary. When you enroll in ChoiceCare, you become a member of a comprehensive health care plan designed to promote good health as well as the delivery of quality care in times of illness or injury.

Preventive Care

Preventive care, including physical examinations, is covered through your PCP. You pay only $5 for each visit to your PCP. Well child visits are also provided through PCPs. No copayment is required for well child visits for members from birth through age 19 which are scheduled within the standards of the American Academy of Pediatrics.

Emergency Care

Medically necessary emergency care is covered anywhere in the world. You can call ChoiceCare for guidance on emergency care 24 hours a day, 7 days a week. There is a $25 copay for medically necessary emergency treatment. This is waived if admitted to the hospital.

Specialty Care

In addition to routine medical care, your PCP helps you get the specialty care you need through a large network of participating providers. When specialty services are necessary, your PCP will refer you to the appropriate specialist. Specialist consultations and treatment; short-term physical, occupational or speech therapy; diagnostic testing and allergy testing and treatment are provided at $5 per visit.

OB/GYN

Female members age 16 and up also have the option to select a participating ChoiceCare Obstetrician /Gynecologist (OB/GYN) who provides care within his/her specialty area without a referral from the PCP. Routine exams, mammography and pap tests are covered for a $5 office visit.

Maternity care, including prenatal visits, delivery, hospital stay and post natal care are covered at 100%.

Hospital Coverage

Your admission to any of the tri-county hospitals is based upon your participating physician's admitting privileges. You will find this information in the ChoiceCare medical directory. Hospital services, including preadmission testing, unlimited room and board in a semiprivate room, physicians' services for surgery and anesthesiology, prescribed medications and diagnostic services are covered at 100%.

Skilled nursing facility care for up to 45 days per calendar year is covered at 100%. Mental health and substance abuse services are also offered.

Centers of Excellence Program

For members requiring complicated transplant surgery, our Centers of Excellence Program provides members with access to highly specialized centers throughout the country.

Health Promotion

Vision care, health promotion and health care education programs are available at discounts through participating vision care centers and health care agencies.

Optional Rider

ChoiceCare offers an optional rider for prescription drug coverage that is accepted at over 90% of the pharmacies in the United States. See ChoiceCare's medical directory for a complete listing of tri-county area pharmacies. There is a $7 copay per prescription (brand and generic) after an annual $50 per person deductible has been met.

There is no annual limit.

Cost

Please see page 50 for payroll or pension deductions.

For Additional Information

To speak with a New York City Account Representative, call ChoiceCare at **(516) 582-1857 or (800) 406-0806**, Monday through Friday, 8:30 a.m. to 5:30 p.m.

You may contact the health plan at:

Corporate Center
395 North Service Road
Melville, New York 11747-3127

CIGNA HealthCare

CIGNA HealthCare is a comprehensive health care plan designed for **New York and New Jersey** residents.

Coverage for non-Medicare eligible retirees and dependents is also available in **Los Angeles, California; and Phoenix, Arizona**. The plan benefits in **New York and New Jersey** are the same as for active employees. There are some differences in plan benefits for **Los Angeles and Phoenix**.

Effective August 1, 1995 CIGNA in New York and New Jersey was no longer available to Medicare-eligible retirees and their Medicare-eligible dependents.

Physician Network

CIGNA HealthCare has over 10,000 physicians located throughout the five boroughs of **New York City, Nassau, Suffolk, Rockland, Putnam, Westchester and Orange Counties, and New Jersey.** CIGNA HealthCare doctors see members in the privacy and comfort of their private offices.

As a CIGNA HealthCare member, you select your own primary care physician from a list of participating doctors. Each adult family member selects an internist or family doctor. Parents select a pediatrician or family doctor for children under 12 years of age. You may choose one doctor for the entire family or, if you prefer, a different doctor for each family member. In addition, each female member may access a participating obstetrician/gynecologist (OB/GYN) for acute gynecologic care, pregnancy care and two exams per year without a referral from your primary care doctor. However, we recommend that you use your primary care doctor for OB/GYN referrals.

Each of CIGNA HealthCare's doctors has been carefully selected and credentialed in accordance with National Committee for Quality Assurance (NCQA) guidelines to ensure that our members receive the best medical care available.

Once you have selected your doctor, you will receive a CIGNA HealthCare membership card showing your doctor's name and telephone number. Your doctor will manage all of your health care needs. If you require the care of a specialist, your doctor will make the necessary referrals and arrangements for you.

All visits to your primary care physician and to CIGNA HealthCare participating specialists, when authorized by your primary care physician, are completely covered. If you are admitted to a CIGNA HealthCare participating hospital by your primary care physician or a participating CIGNA HealthCare specialist, the bills for all authorized care including surgery and anesthesia are covered.

Should you require additional specialty care, physical or rehabilitation therapy, vision or hearing examinations, home care, durable medical equipment, allergy testing and treatments, laboratory testing, X-rays, maternity and well-baby care, you are completely covered if authorized by your primary care physician and provided by a participating CIGNA HealthCare provider.

Emergency Care

Your CIGNA HealthCare coverage protects you 24 hours a day, seven days a week for emergencies. An emergency is defined as sudden and unexpected acute illness, acute pain or accidental injury which if not immediately diagnosed and treated could reasonably be expected to result in serious medical complications or loss of life. Emergencies are covered 100%, except for a $35 copayment charged if you are not admitted to the hospital. Emergencies include heart attack, stroke, loss of consciousness, loss of respiration, convulsions, poisoning and severe pain. Emergency care is covered anywhere in the world.

Optional Rider

An Optional Rider is available to all employees and non-Medicare eligible retirees; for each prescription and refill you will pay only a $3 copayment for a generic prescription and a $6 copayment for a brand name prescription at participating pharmacies. A maintenance drug program (90-day supply) is available through mail order at no additional cost beyond the copayment.

Cost

Please see page 50 for payroll or pension deductions.

For Additional Information

Member services representatives are available daily to answer your questions.

New York	**(800) 345-9458**
New Jersey	**(800) 462-6633**
Los Angeles, CA	**(800) 432-4961**
Phoenix, AZ	**(800) 572-9990**

You may contact the health plan at:

195 Broadway - 8th Floor
New York, New York 10007

NEW YORK • NEW JERSEY • FLORIDA
HIP
HEALTH INSURANCE PLAN OF GREATER NEW YORK

HIP — the Health Insurance Plan of Greater New York — offers you and your family comprehensive hospital and medical benefits from HIP affiliated physicians in the **five boroughs of New York City, Nassau, Suffolk, Westchester, Rockland and Orange counties as well as parts of New Jersey and Florida.**

With HIP/HMO, you and each family member choose a family physician practicing at one of HIP's 56 multispecialty medical centers. Or you may choose an HIP affiliated physician practicing in his or her own office as part of our expanding network of neighborhood physicians. With so many doctors affiliated with HIP, its easy to find one who meets your needs. You can choose different doctors for each member of your family; for example, an internist at an HIP Medical Center and an affiliated pediatrician in an HIP affiliated network office.

You may visit your family physician — and female members may visit the gynecologist — as often as necessary without charge. Simply call for an appointment. Whether it's a routine checkup or a specific medical problem, your family physician coordinates your care and works with specialists from virtually every area of medical practice to provide you with total health care.

You are covered for routine examinations, medical screenings, well-baby care and urgent care, as well as routine foot care and preventive dental care, which includes two examinations and one cleaning a year. Mental health services are available at HIP Mental Health Centers.

HIP medical centers provide a wide range of comprehensive medical services including routine lab, X-ray, mammography and sonography services, along with highly specialized laser, nuclear and fiber optic diagnostic services. Many of these services are offered right in our medical centers.

If you choose an HIP affiliated physician practicing in a neighborhood office as your primary care physician, you and your doctor can still take advantage of all that HIP offers. The specialists, the technology and all the expertise to be found in HIP is available to you and your doctor. Your physician will refer you to appropriate specialists for treatment and services whenever necessary.

HIP is affiliated with many leading area hospitals including Montefiore Medical Center, the New York Hospital-Cornell Medical Center, Beth Israel Hospital, North Shore University Hospital and St. Vincent's Medical Center of Richmond. Should you need inpatient care in a hospital, skilled nursing facility or hospice, you are covered in full when your care is preauthorized by HIP and arranged for and by an HIP affiliated physician.

Emergency Care

HIP provides round-the-clock emergency services whenever and wherever they are needed through our Emergency Services Program - ESP. When your medical center or network physician's office is closed, simply dial 800-HIP-HELP (800-447-4357). You will be connected to affiliated physicians and registered nurses who will evaluate your condition, answer your questions, and provide support, advice and access to care at an after-hours treatment center or an emergency room.

If you experience a medical emergency when traveling outside of the HIP service area — anywhere in the world — you are still covered for hospital and medical care. Simply obtain the care that you need, and notify HIP within 48 hours.

Weight Management, Health And Fitness Programs

HIP has special programs to help you lose weight, stop smoking, reduce stress or simply lead a healthier life. We can help you learn how to prevent illness and manage chronic conditions, such as diabetes and heart disease. We also provide a program for children with asthma.

Florida and New Jersey Service Areas

If you live in Florida, you can choose a physician from HIP's affiliated provider network of physicians, with more than 1,000 physicians in **Broward, Palm Beach and Dade counties in Southern Florida and Pinellas, Hillsborough, Pasco and Hernando counties in the Tampa Bay area.**

In New Jersey, you and each family member choose a family physician practicing at one of HIP's multispecialty medical centers. Or you may choose an HIP affiliated physician practicing in his or her own office as part of our expanding network of neighborhood physicians. HIP affiliated physicians practice in **Bergen, Burlington (except the town of Bass River), Camden, Eastern Passaic (east of and including Pompton Lakes), Essex, Gloucester, Hudson, Middlesex, Somerset, Mercer, Union and parts of Morris, Monmouth, Hunterdon, Atlantic, Ocean and Salem counties**.

Travel Within HIP's Service Areas

If you travel anywhere within HIP's service areas, whether it's New York, New Jersey or Florida, you can arrange to receive HIP's comprehensive care while you are away from home. If possible, call HIP Interplan at 800-223-0654 before you travel to arrange the care you need.

Optional Rider

HIP/HMO offers a rider for prescription drugs (with no copayment) to cover the cost of prescriptions in full when filled at any of HIP's participating pharmacies; and a rider for durable medical equipment and in-hospital private duty nursing.

Cost

Please see page 51 for payroll and pension deductions.

For Additional Information

To learn more about HIP, please write to **HIP at 7 West 34th Street, New York, NY 10001. Or call 800-HIP-NYC9**. During the New York City Transfer Period, specially trained representatives will be available Monday through Friday, 8:00 am to 8:00 pm to answer your questions.

MetroPlus Health Plan

MetroPlus Health Plan (formerly "Metropolitan Health Plan" or "MHP") is a fully-licensed Health Maintenance Organization, offering a full range of services at no cost to **employees of the NYC Health and Hospitals Corporation (HHC) and their dependents,** including full-time students up to age 23, and to non-Medicare eligible retirees.

Currently, MetroPlus is being offered to HHC employees at multiple locations throughout **Manhattan, the Bronx, Brooklyn and Queens.** Membership is open to HHC employees who are Staten Island residents, providing they obtain all health care services from a MetroPlus participating provider in Manhattan, the Bronx, Brooklyn and Queens. MetroPlus sites are easy to reach by public transportation, and are located in the communities where employees live and work.

Upon joining the Plan, members select a primary care physician (PCP) from a panel of qualified physicians who are either Board-certified or Board-eligible in their medical specialties. A member's PCP not only provides routine care, but also coordinates all of the health care needs of his/her patients. MetroPlus' PCPs will serve as members' point of contact for follow-up care, and will work with physicians from virtually every area of medical practice to provide members with comprehensive services. Moreover, once a member selects a PCP, he/she may visit that physician as often as necessary without charge.

MetroPlus members are covered in full for a wide range of primary and preventive health care services, and are offered other features, including doctors' visits, maternity care, well-baby care, hospital/surgical care and emergency services. There are no deductibles, no co-payments, and no bills or claim forms for basic covered services when authorized by MetroPlus Health Plan.

If an urgent medical need or emergency arises, members can call the MetroPlus Hotline at (800) 442-2560, which is available 24 hours/7 days a week. Calls to this Hotline will be answered by specially-trained representatives who can put members in contact with a health professional. It is through this referral process that members will be guided through the options to make an informed decision about their health care.

Out of Area Coverage

If a member needs medical or hospital care which cannot be provided at his/her health care center, or if an emergency occurs outside of MetroPlus' service area, the Plan covers these services in full, when authorized.

Preventive Health Maintenance

Other special features of MetroPlus include specially-trained membership services staff, health education programs, and multilingual staff. Private duty nursing in the hospital, and covered appliances and prosthetics, previously covered under the Optional Rider, are now covered in the basic plan. Full coverage is provided for maternity care services, including but not limited to routine prenatal care and delivery. In addition, female members are able to visit their gynecologist without a referral. MetroPlus also offers allergy testing and diabetic supplies (insulin, testing stripes, etc.) to members as medically necessary at no additional cost.

Optional Rider

Through selection of an optional rider, members receive full coverage on prescription drugs when authorized by a MetroPlus physician. Members can fill prescriptions at any of MetroPlus' more than 1,200 conveniently located, participating pharmacies throughout the City. This service is open to members without a copayment.

MetroPlus Health Plan Medicare

MetroPlus is not offered to Medicare-eligible retirees at this time.

Cost

Please see page 51 for payroll and pension deductions.

For Additional Information

During the City of New York Transfer Period, knowledgeable Customer Service Representatives will be available to provide specific information and assistance to you at **(800) 303-9626**, 9 a.m. - 5 p.m., Monday through Friday. Special arrangements can be made for individuals not able to contact a Representative during these hours.

You may contact MetroPlus Health Plan at:

MetroPlus Health Plan
11 West 42nd Street
New York, NY 10110
(212) 626-8300

Physicians
HEALTH SERVICES

As an Individual Practice Association form of an HMO, Physicians Health Services (PHS) allows member to choose physicians from a Provider Directory of over 10,000 participating physicians located throughout the entire PHS service area. Physicians Health Services is available in the **Bronx, Brooklyn, Queens, Manhattan, Staten Island and Nassau, Suffolk , Westchester, Putnam, Rockland, Orange, Dutchess Counties and the State of Connecticut.** PHS has 20 years of experience in providing access to quality health care coverage through a unique HMO product which allows City of New York employees, retirees and dependents to have direct access to our network of participating specialists.

When you become a member of PHS, you and each member of your family choose a primary care physician from the PHS list of participating providers, thereby maintaining the traditional doctor/patient relationship. However, if you or a member of your family needs to visit a participating PHS specialist you may contact the PHS specialist directly to set up an appointment. PHS allows members to have direct access to PHS participating providers and no written referral is needed to see a participating specialist. **Currently PHS is the only HMO offered to City employees which allows direct access to participating specialists.**

PHS members receive full coverage for inpatient hospital care when arranged for and authorized by their PHS physician. Inpatient care will be provided at one of the approximately 100 hospitals located in the PHS service area.

Office visits are covered after a $10 copayment. Also covered are allergy tests and treatment, laboratory services, X-rays, diagnostic tests, second surgical opinions, well-baby and well-child care, prenatal and postnatal care, services of a surgeon, anesthesiologist, emergency services, mental health care and physical therapy. Eligible dependents are covered to age 19 or to age 23 if a full-time student.

Emergency Care

In an emergency, PHS members are covered anywhere in the world. Emergency coverage is provided for life-threatening emergencies and is subject to a $50 copayment per visit. If a PHS member is admitted to the hospital, the emergency copayment is waived.

Optional Rider

An optional rider is available to employees and retirees which covers prescription drugs, subject to a $10 copayment per prescription with no limit. Mail order is also available, subject to a $10 copayment for a 90 day supply.

Cost

Please see page 51 for payroll and pension deductions.

For Additional Information

If you have any questions about any aspect of the PHS program, please call PHS toll-free at **800-441-5741**, 8:30 a.m. to 5:00 p.m., Monday through Friday.

Crosswest Office Center, Suite 212
399 Knollwood Road
White Plains, NY 10603

During the City of New York Transfer Period, PHS will have a dedicated unit of specially trained representatives available to provide assistance to the employees and retirees of the City of New York. Simply call PHS at 800-441-5741 and identify yourself as a City of New York employee or retiree.

U.S. Healthcare, the largest private practice HMO on the East Coast, has more than 20 years of experience in providing access to quality health care. Today, more than 54,000 participating doctors, hospitals and outpatient facilities deliver care to our HMO members.

Medical care can be obtained through private practice physicians located throughout the **New York City region (the five boroughs and following counties: Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester); the entire states of New Jersey and Connecticut; Pennsylvania (the metropolitan areas of Allentown, Harrisburg, Lancaster, Philadelphia, Pittsburgh and Reading); the metropolitan areas of Boston, Atlanta and Washington D.C.; the entire state of Delaware and Rhode Island; and several counties in Maryland, New Hampshire and Virginia.**

The U.S. Healthcare HMO plan offers comprehensive coverage with the added benefit of low out-of-pocket costs. Each U.S. Healthcare member selects a participating Primary Care Physician who is an internist, family doctor or pediatrician. Additionally, each female member can select a participating gynecologist for routine gynecological care. All routine and preventive care received in the participating Primary Care Physician's office is fully covered with a $5 copayment. This includes physical evaluations, eye exams and well-baby visits. (Well-baby care in New York requires no copayment.)

Specialty care, hospitalization, surgery, intensive care, ambulance service, physical or rehabilitation therapy, home care, allergy treatments, hearing examinations, anesthesia, diagnostic tests and X-rays are fully covered when your participating Primary Care Physician refers you to a network specialist or hospital for a covered service. A $5 copayment is required for each referred visit to a participating specialist. Mental health and substance abuse benefits are also covered. Emergency care is covered anytime, anywhere in the world. In any of these situations, there are no claim forms to fill out and no deductibles to pay.

Please note: Be sure to choose a Primary Care Physician, and where applicable, a pharmacy, for every member of your family when you complete your Health Benefits Application (Form ERB 95).

U.S. Healthcare Special Medical Programs

National Medical Excellence Program®

U.S. Healthcare has established relationships with nationally respected doctors and medical facilities to provide high tech care for the most complex medical conditions when recommended treatment cannot be found locally. U.S. Healthcare will even pay travel expenses for the member and a companion.

U.S. Healthcare Check® Program

This program promotes the prevention and early detection of breast and colorectal cancer. Age-eligible female members receive a mammography referral and instruction on breast self-exam in the mail. Information and screening materials for colorectal cancer are mailed annually to all members 50 and older.

L'il Appleseed® Program

For our pregnant members, this program provides a $40 reimbursement for prenatal educational classes, discounts from the manufacturer on baby care products and a visit from a home care nurse after delivery. In addition, to give women the best chance for a healthy, trouble-free pregnancy, this program helps members and their doctors detect high risk conditions in the pregnancy. If high risk is discovered, a case manager helps to coordinate necessary specialty care for the pregnant member.

Disease Management Programs

U.S. Healthcare has developed special programs for members with chronic illnesses such as asthma, congestive heart failure and diabetes. These programs give members the tools and training they need to control their illness, reduce the need for hospitalizations and improve their quality of life.

Health Improvement Programs

Programs are available that help members to lose or maintain their ideal weight, stop smoking and reduce stress. In addition, U.S. Healthcare offers a reimbursement of 50% of cost (up to $300 a year) for participation in a qualified cardiovascular fitness program.

Optional Rider

An Optional Rider is available for unlimited prescription coverage with a $2.50 copayment per prescription at a selected participating U.S. Healthcare pharmacy. A listing of the U.S. Healthcare participating pharmacies is available in the U.S. Healthcare benefit information packet.

Cost

Please see page 51 for payroll and pension deductions.

For Additional Information

To receive an updated physician directory or to speak to a customer service representative about your U.S. Healthcare benefits and coverage, call **800-445-USHC**. Customer service representatives are available to answer your questions 8 a.m. to 7 p.m., Monday through Friday, and 9 a.m. to 3 p.m. on Saturday. You can also send your questions in writing to: **U.S. Healthcare, 1425 Union Meeting Road, Blue Bell, PA, 19422, Attention: Solutions Department.**

This plan is open to employees and retirees residing in the counties of **Albany, Brooklyn, Broome, Bronx, Columbia, Delaware, Dutchess, Fulton, Greene, Orange, Otsego, Manhattan, Montgomery, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester in New York.**

WellCare of New York (WellCare) is a Health Maintenance Organization (HMO), offering its members the opportunity to receive health care services at a participating physician's private office. Each WellCare member selects his or her own Primary Care Physician (PCP). Physician visits require a $5 copayment.

As a WellCare member you and each member of your family will choose a PCP from WellCare's list of participating providers. For adults, the PCP will specialize in either internal medicine or family practice and, for children, specialization will be in either pediatrics or family practice. Your PCP will coordinate all health care services, including referrals which must be arranged for and authorized by your PCP.

WellCare members receive full coverage for inpatient hospital care when arranged for and authorized by their PCP. Most inpatient care will be provided at the hospital(s) where your PCP or Specialist has admitting privileges, including all hospitals in the WellCare service area. Specialized care not available in local hospitals may be referred to WellCare's tertiary medical centers. In addition, medically necessary services not provided by these hospitals or WellCare affiliated providers will be arranged by your PCP and covered in full.

Comprehensive Coverage

WellCare coverage is comprehensive. Routine health care, office visits, allergy tests and treatment, eye and ear exams, laboratory services, X-rays, diagnostic tests, second surgical opinions, medical social services, health education, well-baby and well-child care, prenatal and postnatal care, services of a physician, surgeons, anesthesiologist, emergency services, skilled nursing care, mental health care, physical therapy and rehabilitation are all covered. Eligible dependents are covered to age 19. Unmarried full-time students are covered to age 25.

Bíenestar

WellCare is also introducing Bíenestar which offers complementary approaches to medicine. These approaches include chiropractic therapy, nutritional counseling, and acupuncture.

Emergency Care

Emergency care is covered, provided that the services are authorized by your WellCare PCP. For life threatening emergencies, members receive immediate care and then are expected to call their WellCare PCP within 48 hours of receiving care. Members are covered 24 hours a day/7 days a week. Emergency care is covered anywhere in the world. There is a $25 copayment for each emergency room visit.

Women's Health Resource Center

One phone call puts WellCare members in touch with a resource service dealing with the many issues facing women in regard to their health and well-being. The Resource Center is able to provide individual patient education and case management to coordinate care.

Mental Health Resources and Referral Center

WellCare members will be connected with a mental health professional who will evaluate, direct, coordinate, and review the member's mental health needs. Assistance can be given in dealing with the full range of problems that affect people and how they cope with themselves, their lives, and their jobs.

Optional Rider

A prescription drug rider, requiring a $5 copayment per prescription at a participating pharmacy is available.

Prescriptions will be dispensed on a generic basis. Those members requesting a brand-name drug must pay the difference between the brand name drug and the generic drug whenever a generic drug is available, plus the $5 copay.

Cost

Please see page 51 for payroll or pension deductions.

For Additional Information

You may contact the plan at:

Executive Woods
4 Palisades Drive
Albany, NY 12205
(518) 446-0200

130 Meadow Avenue
Newburgh, NY 12550
(914) 566-0700

120 Wood Road
Kingston, NY 12401
(914) 334-4000

15 North Mill Street
Nyack, NY 10960
(914) 353-1281

22 Riverside Drive
Carriage House
Binghamton, NY 13905
(607) 724-0050

440 Park Avenue South
New York, NY 10016
(212) 779-3900

During the New York City Transfer Period, specially trained representatives will be available Monday to Friday 8:00 a.m. to 8:00 p.m. at **(800) 288-5441 or (914) 566-7047 (TDD only)** or you may contact one of our local Service Centers.

COMPARISON OF HEALTH MAINTENANCE ORGANIZATION BENEFITS
(Services from Participating Providers Only)

	Outpatient Care / Office Visits	Consultation, Diagnosis, and Treatment by a Specialist	Outpatient Diagnostic Tests (Labs, X-rays, etc.)	Inpatient Hospital Care (room and board, surgery, anesthesia, other hospital services)	Maternity Care (Mother and Newborn)	Emergency Room Care
ChoiceCare	$5 copay	$5 copay; PCP referral required	$5 copay	Covered in full	Covered in full	$25 copay, waived if admitted
CIGNA HealthCare	Covered in full	Covered in full; PCP referral required	Covered in full	Covered in full	Covered in full	$35 copay, waived if admitted
HIP/HMO	Covered in full	Covered in full; PCP referral required	Covered in full	Covered in full	Covered in full	Covered in full
MetroPlus (HHC Employees/ Non-Medicare Retirees only)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Physicians Health Services	$10 copay	$10 copay; No PCP referral required	Covered in full	Covered in full	Covered in full	$50 copay, waived if admitted
U.S. Healthcare HMO	$5 copay	$5 copay; PCP referral required	$5 copay; PCP referral required	Covered in full	$5 copay for OB/GYN visits; Hospital covered in full	$35 copay, waived if admitted
WellCare	$5 copay	$5 copay; PCP referral required	Covered in full	Covered in full	$5 copay for OB/GYN visits; Hospital covered in full	$25 copay, waived if admitted

NOTE: Coverage levels indicated apply only if care is provided or authorized by a participating physician.

COMPARISON OF HEALTH MAINTENANCE ORGANIZATION BENEFITS
(Services from Participating Providers Only)

	Mental Health	Chemical Dependency	Optional Rider	Student Coverage
ChoiceCare	**Inpatient:** Covered in full 30 days per calendar year **Outpatient:** Covered for 20 visits in a calendar year: visits 1-3, $5 copay; 4-20, $25 copay	**Inpatient:** Detox covered in full for 3 periods of detox per calendar year for drugs/alcohol; Rehab not covered **Outpatient:** $5 copay per visit, 60-visit combined ann. max for drug and/or alcohol treatment	**Prescription Drugs:** Unlimited benefit, $7 copay (brand or generic), $50 annual deductible	Covered to age 23
CIGNA HealthCare	**Inpatient:** Covered in full 30 days per 365 day period (23 days of which may be applied to drug and/or alcohol coverage) **Outpatient:** Covered for 20 visits per 365-day period, variable copays up to $25	**Inpatient:** Detox covered in full, 30-day per 365 day period combined ann. max for drug/alcohol treatment (23 days of which will be charged to the mental health benefit); Rehab not covered **Outpatient:** Covered in full, 60-visit per 365 day period combined max. for drug and/or alcohol treatment	**Prescription Drugs:** $3 generic copay, $6 brand copay, mail-order/ maintenance drugs	Covered to age 23
HIP/HMO	**Inpatient:** Covered in full up to 30 days/calendar year, 30 day combined annual max for drug, alcohol, and/or mental health **Outpatient:** 20 visits to HIP mental health centers, $25 copay per visit	**Inpatient:** Detox covered in full, 30 day combined ann. max for drug, alcohol, and/or mental health treatment; Rehabilitation not covered **Outpatient:** Covered in full, 60-visit combined annual max for drug/alcohol treatment	**Prescription Drugs:** Covered in full at HIP pharmacies; **Durable Med. Equip./In-hospital Priv. Duty Nursing**	Covered to age 23
MetroPlus (HHC Employees/ Non-Medicare Retirees only)	**Inpatient:** Covered in full 30 days (psychological testing not covered); 30 day combined ann max for drug, alcohol and/or mental health **Outpatient:** Covered one visit per year for diagnostic purposes	**Inpatient:** Detox covered in full, 30-day combined annual maximum for drug, alcohol and/or mental health treatment; (non-hospital-based inpatient services not covered) **Outpatient:** Covered in full, 60- visit per calendar year combined max for drug and/or alcohol treatment	**Prescription Drugs:** Covered in full at MetroPlus participating pharmacies	Covered to age 23
Physicians Health Services	**Inpatient:** Covered in full up to 30 days at a PHS approved facility **Outpatient:** Covered for 20 visits, $20 copay per visit	**Inpatient:** Detox covered in full at PHS approved facility; Rehab not covered **Outpatient:** $10 copay per visit, 60 visits per calendar year	**Prescription Drugs:** Unlimited benefit; $10 copay, no deductible, 90-day mail supplies	Covered to age 23
U.S. Healthcare HMO	**Inpatient:** Covered in full 35 days per 365 day period **Outpatient:** Covered for 20 visits per 365 day period, $25 copay/visit	**Inpatient:** Detox covered in full for acute treatment; Rehab not covered **Outpatient:** $5 copay per visit, 60-visit combined annual max for drug and/or alcohol treatment	**Prescription Drugs:** Unlimited benefit; $2.50 copay at participating pharmacies	Covered to age 23
WellCare	**Inpatient:** Covered in full, 30 day annual maximum **Outpatient:** 20 visits per year, visits 1-5, $5 copay; 6-20, $10 copay	**Inpatient:** Detox covered in full, 30-day combined ann max for drug and/or alcohol treatment, Rehabilitation covered in full; 30-day combined ann max for drug and/or alcohol treatment **Outpatient:** $5 copay per visit, 60 visit combined annual max for drug/alcohol treatment	**Prescription Drugs:** $5 generic copay at par pharmacies; members pay full additional cost of brand drugs, plus $5 copay. Mail order available	Covered to age 25

POINT-OF-SERVICE PLANS (POS) AND PARTICIPATING PROVIDER ORGANIZATION (PPO)/INDEMNITY PLANS

(For Employees and Non-Medicare Retirees and their dependents)

Point-of-Service (POS) plans offer the freedom to use either a network provider or an out-of-network provider for medical and hospital care. If the subscriber uses a network provider, health care delivery resembles that of a traditional HMO, with prepaid comprehensive coverage and little out-of-pocket costs for services. When the subscriber uses an out-of-network provider, health care delivery resembles that of an indemnity insurance product, with less comprehensive coverage and subject to deductibles and coinsurance.

Participating Provider Organizations (PPO)/Indemnity Plans contract with health care providers who agree to accept a negotiated lower payment from the health plan, with copayments from the subscribers, as payment in full for medical services. When the subscriber uses a non-participating provider, the subscriber is subject to deductibles and/or coinsurance.

Recent Benefit Changes

Effective July 1, 1995

- **Med-Team** has transitioned to DC 37 Med-Team/HealthEase. The service area has expanded to include participating providers throughout the five boroughs of New York City, Nassau and Suffolk counties and across New York State.

Effective October 1, 1995

- **HIP Choice Plus** - Prenotification for medical services is no longer required. Preauthorization is still required for inpatient care in a hospital or skilled nursing facility, ambulatory surgery, home care, MRI, CAT scan and outpatient alcohol or substance abuse treatment.

Effective January 1, 1996

- **Empire Blue Choice** will be changed to **BlueChoice POS**. An expanded provider network including the current participating panel will be offered. Benefit changes will be as follows: skilled nursing covered both in and out-of-network for 60 days; outpatient mental health out-of-network benefits will be covered for 20 visits at 50% of the network allowance; inpatient mental health in-network benefits will decrease from 60 to 30 days, covered in full; outpatient mental health in-network benefits will decrease from 40 to 20 visits with a $25 copayment per visit; emergency room copayment will increase from $25 to $35, waived if admitted; out-of-network chemical dependency coinsurance will be 50% of network allowance. ***Current Empire Blue Choice subscribers will automatically be transferred in January 1996 to BlueChoice POS if they do not elect another health plan during the Transfer Period.***
- **Sanus Plus** has expanded its service area to include the entire State of New Jersey.
- **U.S. Healthcare's Choice of Excellence Plan** will be replaced by the **Quality Point-of-Service Program**. Unlike U.S. Healthcare's Choice of Excellence plan, you may use out-of-network hospitals and doctors of your choice (subject to deductibles and coinsurance) without obtaining referrals, even for primary care. Benefit changes to the in-network program will be as follows: increase in copayment for physicians' office visits from $2 to $5; emergency room copayment increase from $15 to $35; and all mental health visits will cost $25 per visit. A $5 copayment is also required for each referred visit to a participating specialist. U.S. Healthcare has expanded its service area to include Dutchess, Sullivan, and Ulster counties in New York, as well as the metropolitan area of Atlanta, Georgia, the entire state of Rhode Island, and several counties in Virginia. **Current Choice of Excellence subscribers will automatically be transferred in January 1996 to the Quality Point-of-Service plan if they do not elect another health plan during the Transfer Period.**

Special Notes

- Employee and Non-Medicare Retiree premium costs for each POS and PPO/Indemnity plan are listed on pages 50 and 51.
- For Medicare-eligible retirees and their Medicare-eligible dependents, these health plans provide benefits similar to those described in each summary. For information about Medicare enrollee coverage, please refer to the health plans in Section Three III on pages 24 through 33.

BLUECHOICE®

Empire Blue Cross and Blue Shield's HMO-based Point-of-Service (POS), BLUECHOICE POS program is a new health care plan program for New York City employees, retirees, and their families from Empire Blue Cross and Blue Shield. With this program, you actually have two health benefits plans - an in-network HMO plan with covered-in-full benefits, and a freedom of choice plan with deductibles and coinsurance.

You can either visit the personal doctor you selected from Empire's large network (2,700 family practitioners, 4,600 specialists), or go out-of-network to any physician you choose. In fact, you can use the network for some services and go out-of-network for others. Either way, you receive benefits for a variety of services. When you receive care through your primary care physician (PCP) at network providers, most of your benefits are covered in full. By using your PCP you have no deductible, no coinsurance, no maximums, and virtually no claims to file.

Empire has selected a broad network of doctors throughout the New York area to offer you wide access to quality care. The network has doctors and hospitals in **all five boroughs, throughout Nassau and Suffolk Counties on Long Island, and across Mid-Hudson and Upstate New York.**

When you enroll, each family member can select their own PCP from the participating Primary Care Physician Directory. Your PCP then provides basic health care services, makes referrals to specialists as needed, and coordinates inpatient, outpatient, and medical services. If you move or your needs change, you can switch PCPs by notifying Empire Blue Cross Blue Shield.

The program offers a full range of in-network preventive care, including routine physicals, gynecological exams, mammography screenings, routine nursery care, immunizations and well baby/child care. The plan provides broad hospital and medical coverage, including office visits to your PCP for a $3 copay. In addition, you will be covered for emergency care at almost 7,000 participating hospitals nationwide. Benefits for emergency care are available in-network or out-of-network. You must call your PCP within 24 hours for in-network coverage.

When you use a doctor who is not part of the network, or self-refer, the program still covers most of these hospital and medical services. Empire treats out-of-network services just like traditional health insurance, with benefits subject to deductibles ($350 individual/$1,000 family) and coinsurance (for most services the plan pays 80% up to an out-of-pocket maximum of $2,500 individual/$7,500 family). Empire then reimburses you the allowed amount (either 100% of the customary charge or the amount Empire would have paid a participating provider).

Certain out-of-network services (inpatient or outpatient hospitalization, surgery, private duty nursing services, skilled nursing facility or home care) are subject to pre-certification by the Telephone Authorization Program (TAP). You must call the TAP Center at the number shown on your ID card before receiving care. TAP gives you the answers you need to questions about care options and benefits availability. TAP helps you make informed health care decisions. If you do not comply with TAP requirements, your hospital benefits will be reduced by 50% for inpatient hospital stays and 10% for other services. Inpatient hospital and skilled nursing facility benefits will be reduced up to $1,000 per admission and ambulatory surgery by $1,000 per occurrence in addition to the out-of-network deductible and coinsurance requirements.

Personal Health Advisor℠ Program

This program gives members access to health care information through a toll-free, confidential phone service. Specially-trained registered nurses are on-hand 24 hours a day, seven days a week, to help you with your medical questions and concerns. The Personal Health Advisor program also includes an audio health library that provides recorded information on over 430 health care topics in both English and Spanish. After a member listens to an audio library selection, he or she can then choose to speak to a nurse counselor or have printed copies of information sent to their home address.

Empire Baby Care

Empire BabyCare℠ is a comprehensive maternity management program aimed at enhancing prenatal care. It is automatically available to expectant mothers enrolled in Empire's HMO-based Point-of-Service (POS) product. The program works in conjunction with the expectant mother and her physician and offers various services including educational materials, access to a network of perinatologists and home health care.

Optional Rider

Empire offers an optional rider for prescription drug coverage. You can use your prescription drug card at over 4,100 Empire Network Pharmacies throughout the tri-state area. Present your card and prescription to the pharmacist. You then pay either the $5 copay for each prescription or the pharmacy's customary charge, whichever is less. If you need prescription medication on a regular or long-term basis, you can also order up to a 100 unit supply through the mail service program, subject to the $5 copay. You must pay any additional charges if you or your provider request a brand-name drug.

Cost

Please see page 50 for payroll and pension deductions.

For Additional Information

To keep you informed, Empire has staffed the **Dedicated Service Center** with customer service representatives specially trained to explain the program. If you would like additional information about the program during open enrollment, please call **800-767-8672 or 212-476-7666.** For your convenience, telephone hours are from 8:30 am to 5:30 pm, Monday through Fridays.

You may contact the plan at:

Empire Blue Cross Blue Shield
City of New York Dedicated Service Center
P.O. Box 4883 Grand Central Station
New York, New York 10163

The good news in health care.℠

GHI/Comprehensive Benefits Plan

GHI has been providing City of New York employees access to quality affordable health care for more than 30 years. With the GHI-CBP, you have the freedom to choose any physician worldwide. You can select a GHI Participating Provider and not pay any deductibles or coinsurance, or go out of network and still receive coverage, subject to deductibles and coinsurance.

Participating Provider Benefits

If you choose care from any of GHI's over 40,000 Participating Physicians and other health care providers of which nearly 24,000 are located in the New York area, you will receive paid-in-full benefits, except for a $10 copayment for home and office visits. (Separate copayments apply for out-of-hospital X-rays and laboratory examinations.) GHI's provider network includes all medical specialties. When you need specialty care, **you select the specialist and make the appointment**. Payment for services will be made directly to the provider - you will not have to file a claim form when you use a GHI Participating Provider.

GHI has developed several specialized provider networks that offer important savings through paid-in-full benefits:

Home Care Services: These services include intermittent home care services, home infusion therapy, private duty nursing and durable medical equipment. Benefits are paid-in-full when pre-certified by the GHI Managed Care Department. Contact GHI Managed Care at (212) 615-4662 in New York City; or 800-223-9870 outside New York City. Durable medical equipment is subject to an annual $100 per person deductible. Coverage for home infusion therapy is available only through GHI participating providers, but all other services can be obtained through non-participating providers, subject to separate annual deductibles and coinsurance.

Enhanced Mental Health and Chemical Dependency Program: This plan offers both inpatient and outpatient chemical dependency and mental health benefits. You can choose from over 6,000 psychiatrists, psychologists, social workers and other providers in the metropolitan New York City area who comprise the GHI Behavioral Management provider network. Out of network benefits are also available. Complete details on this program are available by calling GHI at 800-NYC-CITY.

Centers of Specialized Care: This network of specialty hospitals offers focused expertise in cardiac care and certain transplant procedures. These services are paid-in-full, without deductibles or coinsurance, when provided at a Centers of Specialized Care hospital. Details are available by calling GHI at 800-223-9870.

Non-Participating Provider Benefits

When you do not use the services of a participating provider, GHI provides coverage for the services of non-participating providers. Payment for these services is made directly to you under the NYC Non-Participating Provider Schedule of Allowable Charges (Schedule). The rate at which you will be reimbursed for a particular service is contained within the Schedule. These reimbursement rates were originally based on 1983 procedure allowances, and some have been increased periodically. The reimbursement levels, as provided by the Schedule, may be less than the fee charged by the non-participating provider. Please note that certain non-participating provider reimbursement levels may be increased if you have the optional rider. The subscriber is responsible for any difference between the fee charged and the reimbursement, as provided by the Schedule. A copy of the Schedule is available for inspection at GHI.

Non-participating provider reimbursement is subject to calendar year deductibles ($175 per person, up to a maximum of $500 per family); a calendar year benefit maximum ($200,000 per person); and a lifetime maximum ($1 million per person).

If you choose non-participating providers for predominantly in-hospital care and incur $3,000 or more in covered expenses (based on physicians' reasonable and customary charges, as determined by GHI), you are eligible for additional "Catastrophic Coverage." Under this coverage, GHI pays 100% of reasonable and customary charges, as determined by GHI.

Optional Rider

Additional coverage is available for employees and non-Medicare eligible retirees who elect the GHI-CBP Optional Rider. These benefits include:

- Prescription drug coverage through TelePAID pharmacies. Benefit pays pharmacists 80% of the preferred provider network allowed charge for generic drugs and brand-name medications with no generic equivalents. You are responsible for the remaining 20%. The plan pays 60% of the allowed charge for all other brand-name drugs. If a non-TelePAID pharmacy is used, the employee pays the pharmacy and files a claim with PAID Prescriptions, Inc. Maintenance drug coverage is subject to an $8 co-pay for generic drugs/$15 co-pay for brand-name drugs for a maximum 60-day supply. Prescription drug coverage is subject to an annual $150/individual and $450/family deductible.
- Coverage for unmarried dependent full-time students to age 23.
- Enhanced non-participating provider schedule for certain services. An increased plan benefit calendar-year maximum to $400,000 per person if you use non-participating providers. Up to $200,000 can be used for Private Duty Nursing.
- Additional outpatient psychiatric and inpatient chemical dependency treatment services available. See brochure or call 800-NYC-CITY for details about this benefit.

Hospital Pre-Admission and Medical Care Requirements

NYC HEALTHLINE: Enrollees must call NYC HEALTHLINE (800-521-9574) prior to any scheduled hospital admission, any surgical procedure rendered in the outpatient department of a hospital, or having certain procedures performed in a doctor's office. Failure to call NYC HEALTHLINE may result in a penalty of up to $500 from either your GHI or EBCBS coverage. See the NYC HEALTHLINE brochure ("3 Smart Reasons") or your plan booklets for details about this important program. For chemical dependency or psychiatric admissions, call 800-NYC-CITY.

Cost

Please see page 50 for payroll and pension deductions.

If you have any questions regarding the GHI-CBP, call the GHI City of New York Employee Hotline: **(212) 799-6700**.

You may contact the health plan at:

Group Health Incorporated
441 Ninth Avenue
New York, New York 10001
(212) 501-4444

Empire Blue Cross/Blue Shield Hospital Plan

The Empire Blue Cross and Blue Shield Hospital Plan offers City of New York employees, retirees and their families enrolled in the GHI/Comprehensive Benefits Plan broad protection against the high cost of hospital care. With the Blue Cross and Blue Shield hospital identification card, employees and their families have admission to more than 7,000 participating hospitals across the country. Because of Empire's agreements with area hospitals, the hospitals file claims directly with Empire, nearly eliminating your up-front payments and claims filing.

Inpatient Care

After you meet your $200 deductible per admission ($500 annual maximum per person), Empire's Hospital Plan offers you paid-in-full inpatient care for up to 75 days of hospitalization. You receive benefits if you require hospitalization for illness or injury. You are covered for such inpatient services as semi-private room and board, general nursing care, drugs and medicines, the use of blood transfusion equipment, and the administration of blood or blood derivatives.

Maternity benefits are covered in full, subject to a $200 deductible. Nursery charges are covered in full after a $240 deductible. Newborn children are automatically covered from birth for treatment of illness or injury. In addition, benefits are provided for air ambulance services (not subject to the inpatient deductible) to hospitals in connection with an emergency situation when no other transportation (such as commercial airlines or surface transportation) is available.

Each family member must meet his or her own deductible; if you are admitted again within 90 days, you do not have to meet another deductible. In addition, you do not have to pay a deductible for the following: ill newborns who remain in the hospital after birth; or hospice benefits.

Outpatient Care

Outpatient benefits are an important part of your coverage. A total of 30 visits are available to you during each calendar year for minor surgery and presurgical testing.

Other outpatient treatment and ambulatory surgery are covered at 80% of approved charges. You pay 20% coinsurance up to a maximum of $200 per calendar year. After that, such treatment or surgery is covered in full. (Doctor charges for other than specialty and/or follow up care should be part of the hospital charges for all in-area hospitals; out-of-area hospital doctor charges are subject to the terms and limitations of the contract.) Outpatient emergency care is detailed below.

Emergency Care

There is a $25 co-payment for emergency room care such as treatment for Sudden and Serious Illness within 12 hours of onset and Accidental Injury treatment within 72 hours after the accident. This co-payment is waived if the patient is admitted to the same hospital. Charges for specialty doctors and/or follow up care should be submitted to GHI.

Hospice Care

The Hospital Plan also offers coverage for hospice care for up to 210 days. Full benefits for this service are provided when they are rendered in a participating facility.

Worldwide Protection

Empire's Hospital Plan also offers you Blue Cross hospital benefits anywhere in the world.

If you need inpatient care you will receive full benefits if you are admitted to a Participating Hospital or any general hospital.

If you need outpatient care you will receive full benefits in a Participating Hospital or any general hospital for use of a hospital's facilities for a surgical operation. For emergency care in non-participating hospitals, you may not be covered in full for physicians' or specialists' services.

Hospital Pre-Admission and Medical Care Requirements

NYC HEALTHLINE: Enrollees must call NYC HEALTHLINE (800-521-9574) prior to any scheduled hospital admission, any surgical procedure rendered in the outpatient department of a hospital, or having certain procedures performed in a doctor's office. Failure to call NYC HEALTHLINE may result in a penalty of up to $500 from either your GHI or EBCBS coverage. See the NYC HEALTHLINE brochure ("3 Smart Reasons") or your plan booklets for details about this important program.

Optional Rider

Additional coverage is available for employees and non-Medicare eligible retirees who elect the Optional Rider. These benefits include:

- 365 days of hospital protection
- extended hospital coverage for unmarried full-time dependent students to age 23.

Cost

Please see page 50 for payroll and pension deductions.

For Additional Information

To keep you informed about the Empire Blue Cross and Blue Shield Hospital Plan, Empire has staffed the **Dedicated Service Center** with customer service representatives specially trained to explain the program. If you would like additional information about Empire's Hospital Plan during open enrollment, please call **212-476-7888** (**800-433-9592** outside New York State). Center telephone hours are from 8:30 am to 5:30 pm, Monday through Friday.

You may contact the plan at:

Empire Blue Cross and Blue Shield
City of New York Dedicated Service Center
P.O. Box 4883 Grand Central Station
New York, NY 10163

NEW YORK • NEW JERSEY • FLORIDA
HIP
HEALTH INSURANCE PLAN OF GREATER NEW YORK

HIP CHOICE PLUS combines all the benefits of high quality, affordable in-network managed care — including HIP medical centers, network of HIP affiliated physicians, comprehensive benefits, accessibility and convenience with the freedom to choose any physician, any hospital, anywhere.

There is no charge if you use doctors, hospitals and services in the HIP network. Out-of-network charges are subject to deductibles and coinsurance.

In-Network Benefits

In-network, you and your family receive comprehensive hospital and medical benefits from HIP affiliated physicians in the **five boroughs of New York City, Nassau, Suffolk, Westchester, Rockland and Orange counties as well as parts of New Jersey and Florida. (See page 7 HIP/HMO for Florida and New Jersey service areas.)**

You and each family member choose a family physician practicing at one of HIP's 56 multispecialty medical centers. Or you may choose an HIP affiliated physician practicing in his or her own office as part of our expanding network of neighborhood physicians.

You are covered for routine examinations, medical screenings, well-baby care and urgent care, as well as routine foot care and preventive dental care, which includes two examinations and one cleaning a year. Mental health services are available at HIP Mental Health Centers.

HIP medical centers provide a wide range of comprehensive medical services including routine lab, X-ray, mammography and sonography services, along with highly specialized laser, nuclear and fiber optic diagnostic services.

If you choose an HIP affiliated physician practicing in a neighborhood office as your primary care physician, you and your doctor can still take advantage of all that HIP offers. The specialists, the technology and all the expertise to be found in HIP is available to you and your doctor. Your physician will refer you to appropriate specialists for treatment and services whenever necessary.

HIP is affiliated with many leading area hospitals including Montefiore Medical Center, The New York Hospital-Cornell Medical Center, Beth Israel Hospital, North Shore University Hospital and St. Vincent's Medical Center of Richmond. Should you need hospital care, you are covered in full when your care is arranged by an HIP affiliated physician.

Emergency Care

HIP provides round-the-clock emergency services whenever and wherever they are needed through our Emergency Services Program - ESP. When your medical center or network physician's office is closed, simply dial 800-HIP-HELP (800-447-4357). You will be connected to affiliated physicians and registered nurses who will evaluate your condition, answer your questions and provide support, advice and access to care at an after-hours treatment center, or an affiliated hospital emergency room.

If you experience a medical emergency when traveling outside of the HIP service area — anywhere in the world — you are still covered for hospital and medical care. Simply obtain the care that you need, and notify HIP within 48 hours.

Out-Of-Network Benefits

HIP Choice Plus offers you the freedom to choose medical and hospital care outside the HIP Network. When you choose to use a physician not affiliated with HIP, you are reimbursed after the deductible for up to 80% of the reasonable charges. Your hospital stay is covered in full as long as it is preauthorized by HIP. Routine preventive care such as periodic health exams, routine immunizations and eye exams are covered when provided by an HIP affiliated physician. Routine pediatric and well baby care is covered up to 80% of customary charges. For maternity care, newborn nursing services and mother's hospital services are covered in full.

Following an annual deductible of $250 per individual or $500 per family, members will receive 80% reimbursement of customary charges. Member must first contact the HIP Service Plus Unit (800-447-1758) to obtain preauthorization for hospital and skilled nursing facility care, ambulatory surgery, home care, MRI's, CAT scans and outpatient alcohol and substance abuse treatment. Failure to obtain preauthorization will result in a 50% penalty. Subscriber must pay excess above customary charge. When 20% coinsurance reaches $2500 per individual or $7,000 per family in a calendar year HIP Choice Plus pay 100% of the customary charges for the remainder of the calendar year up to an annual maximum of $250,000.

The Service Plus Unit will explain the HIP Choice Plus benefits, how to obtain service within HIP and what steps to take should you choose a non-affiliated physician or service.

Travel Within HIP's Service Areas

If you travel anywhere within HIP's service areas, whether it's New York, New Jersey or Florida, you can arrange to receive HIP's comprehensive care while you are away from home. If possible, call HIP Interplan at 800-223-0654 before you travel to arrange the care you need.

Optional Rider

A rider is available for HIP CHOICE PLUS members that completely covers (no copayment) the cost of prescriptions ordered by an HIP affiliated physician and filled at any of HIP's 1,500 participating pharmacies. There is a $10 copayment for prescriptions from physicians who are not affiliated with HIP when they are filled at participating pharmacies. Some prescriptions require additional fees. If your prescription is issued by a physician not affiliated with HIP and is filled at a non-participating pharmacy, HIP will reimburse you according to an established fee schedule and require a $10 copayment.

Cost

Please see page 51 for payroll and pension deductions.

For Additional Information

To learn more about HIP, please write to **HIP at 7 West 34th Street, New York, NY 10001. Or call 800-HIP-NYC9**. During the New York City Transfer Period, specially trained representatives will be available Monday through Friday, 8:00 am to 8:00 pm to answer your questions.

DC 37 MED TEAM/HEALTHEASE℠

Available only to DC 37 members, retirees, and their families, DC 37 Med-Team/HealthEase offers a full range of coverage, all provided within local communities where members live or work. The DC 37 Med-Team/HealthEase program offers the convenience of an extensive network of participating physicians, throughout the five boroughs of **New York City, Nassau and Suffolk counties and across New York State.**

The DC 37 Med-Team/HealthEase program provides comprehensive hospital and medical benefits through a network of over 2,300 primary care physicians (PCP) and over 5,600 referral specialists. With the DC 37 Med-Team/HealthEase program, you and your family can take advantage of receiving benefits through network physicians for a $10 copayment or you may choose a non-network physician, where your coverage will be subject to higher levels of out-of-pocket expenses.

In-Network Benefits

When you enroll in DC 37 Med-Team/HealthEase, you and each member of your family select a personal physician from our Primary Care Physician Directory. Your PCP then provides basic health care services and coordinates all your health care needs. This includes referrals to specialists, laboratory tests, x-rays, and hospital inpatient and outpatient admissions when necessary. If you move or your needs change, you can switch PCP's for any family member by notifying Empire Blue Cross Blue Shield's HealthEase member services.

The DC 37 Med-Team/HealthEase program offers a full range of in-network preventive care, including routine physical examinations, gynecological exams, mammography screening, routine nursery care, immunizations and well baby/child care. The program provides broad hospital and medical coverage including office visits to your PCP for a $10 copay. Hospital admissions in-network are covered in full except for a $100 co-payment per confinement. After the total hospital admissions copayments reach $300 for your family in a calendar year, no further hospital admission copayments will be required for the remainder of the calendar year.

Additionally, emergency care will be covered at over 7,000 participating hospitals nationwide. A broad range of benefits are provided for emergency care in-network or out-of-network. Remember to call your PCP or the Managed Benefits number within two days; otherwise, your benefits will be reduced.

Out-of-Network Benefits

DC 37 Med-Team/HealthEase provides you the lowest out-of-pocket costs when you use your PCP and the network providers your PCP sends you to. You may prefer to visit providers who are not in our network or receive care without your PCP's approval. This is called "out-of-network care". If you choose to go out of the network to receive care, out-of-network benefits will be subject to deductibles ($350 individual/$700 family) and coinsurance (the plan pays 70% up to an out-of-pocket maximum, excluding deductibles, of $3,000 individual/$9,000 family). DC 37 Med-Team/ HealthEase then reimburses you the allowed amount (either the charge or the amount DC 37 Med-Team/ HealthEase would have paid a participating provider, whichever is less).

Anytime your PCP does not provide or preauthorize service, you must call Empire Blue Cross Blue Shield's Managed Benefits Program (800-805-4712) before receiving care - for example, two weeks before non-emergency hospitalization, or within two business days after an emergency hospital admission. The Managed Benefits Program gives you the answer you need to questions about care options and benefits availability. Failure to comply with the Managed Benefits Program requirements will result in a reduction of hospital benefits of $250 per day, up to a maximum of $500 per admission in addition to the out-of-network deductible and coinsurance.

Catastrophic Medical Benefit Plan

The DC 37 Health and Security Plan provides additional coverage of $1,500 per person, up to $4,500 per family toward the out-of-pocket maximum.

Specialty Programs

Empire BabyCare℠

DC 37 Med-Team/HealthEase members are automatically eligible for the Empire BabyCare program. This program is a comprehensive maternity management program aimed at enhancing prenatal care. The program helps physicians identify women who are potentially at risk for premature delivery and provides the physician with access to services to more effectively manage these cases.

Personal Health Advisor℠ Program

With the Personal Health Advisor program, DC 37 Med-Team/ HealthEase members have access 24 hours a day, to a professional resource who can answer health care-related questions. The Personal Health Advisor service provides a toll-free number, and a specially trained registered nurse with at least five years nursing experience to answer member's health care questions. Members can also call toll-free to the Audio Health Library for prerecorded information on more than 400 health care topics or request literature to be sent to their home.

Cost

There are no payroll or pension deductions for this plan.

For Additional Information

If you have questions or would like additional information, please call our member service representatives at **800-342-9741** from 8:30 am to 4:45 pm any business day. When you call, please identify yourself as a DC 37 member.

You may write to the plan at:

DC 37
125 Barclay Street - 3rd Floor
New York, New York 10007

Personal Health Advisor is a service mark of Access Health Marketing, Inc.

New York Life/Sanus Plus serves **New York City, Nassau, Suffolk, Westchester, Putnam, Orange and Rockland counties in New York; and the entire State of New Jersey.**

New York Life/Sanus Plus is available to retirees living in **Houston and Dallas/ Ft. Worth, Texas; St. Louis, Missouri; and the Washington, D.C. area.** While the plan benefits in these locations are similar to the benefits offered in New York, there are some differences in copayments and deductibles.

How New York Life/Sanus Plus Works

New York Life/Sanus Plus offers New York City employees and retirees a "point of service plan" that lets you choose at any time between physicians in the managed care network and physicians outside the network. You can switch back and forth without having to get prior approval.

If you choose a physician from the network, you pay only $5 for a visit to your doctor, including X-rays, tests, and lab fees. There is no paperwork. You simply present your New York Life/Sanus Plus member's card. There is no charge for well-baby and well-child care visits including all immunizations to age 19. When authorized by your New York Life/Sanus Plus primary care physician, New York Life/Sanus pays 100% of all specialty care, unlimited hospitalization (30 days for mental health), surgery and anesthesia. There are no co-payments for in-network referrals to specialists.

If you choose a non-New York Life/Sanus Plus doctor, you will be reimbursed directly, subject to the following yearly deductibles: $350 per person with a maximum of $1,000 per family; a calendar-year benefit maximum of $200,000 per person; and a lifetime benefit maximum of $1,000,000 per person. Payment is 75% of the in-network allowable charge. Maximum out-of-pocket costs for members, including all out-of-pocket costs, except emergency room co-payments, are $2,500 per person or $7,500 per family; beyond those amounts, New York Life/SanusPlus reimburses you at 100% of the in-network allowable charge. There is a copay of $200 for each out-of-network hospital admission, subject to an annual maximum of $500. Private duty nursing care obtained out of the network is reimbursed at 75% of the in-network allowable charge with a maximum calendar-year benefit of $2,500.

The New York Life/Sanus network of hospitals includes many hospitals in the New York and New Jersey metropolitan area.

There is a penalty of $500 if you fail to notify New York Life/ Sanus Plus of your admission to a hospital.

Emergency Care

Emergency care is covered anywhere in the world; if you are unable to use a plan hospital, New York Life/Sanus Plus will pay the non-plan hospital or physician, or reimburse the member. Members must notify New York Life/Sanus Plus within 48 hours of the onset of emergency for authorization.

Additional Benefits

The following additional benefits are covered when using a New York Life/Sanus Plus network provider:

Mammograms are provided at no charge once a year for females over 18; or at any age for females with prior history of breast cancer or a mother or sister with a prior history. Family planning services are available as follows: counseling at a copay of $5 per visit; IUD or diaphragm at a copay of $5 plus a charge of $25; tubal ligation at a copay of $5 plus a charge of $100 ; vasectomy at a copay of $5 plus a charge of $75; Norplant implant at a copay of $5 plus a charge of $100; infertility diagnostic testing at a copay of $5; and artificial insemination at a copay of $5.

A comprehensive dental plan is available that provides a free clinical exam and treatment plan. The full range of dental services, including orthodontics is available subject to the schedule of co-payments printed in the New York Life/SanusPlus information booklet.

A vision plan is available as follows: vision exam every 2 years, including refractions for a copay of $5; eyeglasses for a copay of $10; contact lenses for a copay of $25.

Allergy testing is free. Diabetic supplies are free, e.g., insulin; syringes; test strips; infusion devices; monitors; related supplies.

The detection and correction of body distortion (Chiropractor Services) has a maximum calendar year benefit of $500.

Optional Rider

An optional prescription drug program is available as follows: generic drugs for a copay of $3 with no deductible; brand-name drugs for a copay of $10 with no deductible. Birth control pills are available.

Cost

Please see page 51 for payroll or pension deductions.

For Additional Information

You may contact the plan at:

New York Life/Sanus Plus
75-20 Astoria Blvd.
Jackson Heights, NY 11370
800-4NY-SANUS (800-469-7268)

Quality Point-of-Service℠

The U.S. Healthcare Quality Point-of-Service℠ (QPOS) Program offers all of the comprehensive benefits of the U.S. Healthcare HMO plan with the added freedom to choose your own doctors and hospitals. You can visit your U.S. Healthcare participating Primary Care Physician for a $5 copay, there are no deductibles or coinsurance. There is also a $5 copay, with no deductibles or coinsurance, when you visit specialists that are referred by your participating Primary Care Physician. Plus, like a traditional plan, you may use out-of-network providers or visit a doctor without a referral (this is called self-referral) subject to deductibles and coinsurance.

More than 54,000 doctors, hospitals and outpatient facilities participate in the network. U.S. Healthcare has more than 20 years of experience in providing access to quality health care. Personal care can be obtained through private practice physicians located throughout the **New York City region (the five boroughs and following counties: Dutchess, Nassau, Orange, Putnam, Rockland, Suffolk, Sullivan, Ulster and Westchester) the entire states of New Jersey and Connecticut; Pennsylvania (the metropolitan areas of Allentown, Harrisburg, Lancaster, Philadelphia, Pittsburgh and Reading); the metropolitan areas of Boston, Atlanta and Washington D.C.; the entire states of Delaware and Rhode Island; and several counties in Maryland, New Hampshire and Virginia.**

QPOS Program Referred Benefits

Each U.S. Healthcare member selects a participating Primary Care Physician who is an internist, family doctor or pediatrician. Additionally, each female member can select a participating gynecologist for routine gynecological care. All routine and preventive care received in the participating Primary Care Physician's office is covered with a $5 copayment. This includes physical evaluations and well-baby visits. (Well-baby care in New York requires no copayment.)

With a referral from your participating Primary Care Physician, specialty and hospital care are fully covered. A $5 copayment is required for each referred visit to a participating U.S. Healthcare specialist. In addition, referred maternity care, home care and mental health and substance abuse treatment are covered. Finally, emergency care is covered anytime, anywhere in the world. For any of these situations, there are no claim forms to fill out and no deductibles or coinsurance to pay.

Please note: Be sure to choose a Primary Care Physician, and where applicable, a pharmacy, for every member of your family when you complete your Health Benefits Application (Form ERB 95).

QPOS Program Self-Referred Benefits

If you choose to visit a doctor or hospital without a referral from your participating Primary Care Physician, (whether in or out of network), you must satisfy an annual deductible of $250 for an individual or $500 for a family. Thereafter, you will be reimbursed for 80% of the Health Insurance Association of America customary and reasonable fee. Once you have paid $2,500 in coinsurance ($7,500 for families), you will be reimbursed 100% of the customary and reasonable fee for covered charges up to the annual maximum benefit of $250,000. For self-referred hospitalization, U.S. Healthcare must be notified five days before a planned admission to avoid a 50% reduction in benefits. You are solely responsible for amounts in excess of customary and reasonable fees.

Most preventive care is covered exclusively through participating Primary Care Physicians. Preventive care for children, as well as routine gynecological exams and Pap smears are fully covered when you visit your U.S. Healthcare participating provider. Well child care is also covered out-of-network, subject to deductibles and coinsurance. Mental health care outside the U.S. Healthcare network is covered at 50% of the customary and reasonable fee up to a lifetime maximum benefit of $50,000. Chiropractic care is covered 80% after the deductible has been satisfied, with a $1,000 annual maximum.

U.S. Healthcare Special Medical Programs

National Medical Excellence Program®

U.S. Healthcare has established relationships with nationally respected doctors and medical facilities to provide high tech care for the most complex medical conditions when recommended treatment cannot be found locally. U.S. Healthcare will even pay travel expenses for the member and a companion.

U.S. Healthcare Check® Program

This program promotes the prevention and early detection of breast and colorectal cancer. Age-eligible female members receive a mammography referral and instruction on breast self-exam in the mail. Information and screening materials for colorectal cancer are mailed annually to all members 50 and older.

L'il Appleseed® Program

For our pregnant members, this program provides a $40 reimbursement for prenatal educational classes, discounts from the manufacturer on baby care products and a visit from a home care nurse after delivery. In addition, to give women the best chance for a healthy, trouble-free pregnancy, this program helps members and their doctors detect high risk conditions in the pregnancy. If high risk is discovered, a case manager helps to coordinate necessary specialty care for the pregnant member.

Disease Management Programs

U.S. Healthcare has developed special programs for members with chronic illnesses such as asthma, congestive heart failure and diabetes. These programs give members the tools and training they need to control their illness, reduce the need for hospitalizations and improve their quality of life.

Health Improvement Programs

Programs are available that help members to lose or maintain their ideal weight, stop smoking and reduce stress. In addition, U.S. Healthcare offers a reimbursement of 50% of cost (up to $300 a year) for participation in a qualified, cardiovascular fitness program.

Optional Rider

An Optional Rider is available for unlimited prescription coverage with a $2.50 copayment per prescription at a selected participating U.S. Healthcare pharmacy. A listing of the U.S. Healthcare participating pharmacies is available in the U.S. Healthcare benefit information packet.

Cost

Please see page 51 for payroll and pension deductions.

For Additional Information

To receive an updated physician directory or to speak to a customer service representative about your U.S. Healthcare benefits and coverage, call **(800) 445-USHC**. Customer service representatives are available to answer your questions 8 a.m. to 7 p.m., Monday through Friday, and 9 a.m. to 3 p.m. on Saturday. You can also send your questions in writing to:

U.S. Healthcare
1425 Union Meeting Road
Blue Bell, PA, 19422
Attention: Solutions Department

COMPARISON OF POINT-OF-SERVICE (POS) PLAN
AND PREFERRED PROVIDER ORGANIZATION (PPO) / INDEMNITY PLAN BENEFITS
(Services Both In- and Out-of-Network)

	Out-of-Network Coverage for Physician Services	Physician's Office Visits	Outpatient Diagnostic Tests (Labs, X-rays, etc.)	Inpatient Hospital Care (room & board, surgery, anesthesia, other hospital services)	Maternity Care (Mother and Newborn)
Empire Blue Cross Blue Shield BlueChoice POS	After the deductible ($350 Ind / $1,000 Fam), the plan pays 80% of customary charges or network allowance After expenses reach $2,500 Ind / $7,500 Fam, the plan pays 100% of customary charges or network allowance	In-Network $3 copay Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network Deductibles and coinsurance
GHI- CBP / Empire Blue Cross Blue Shield	After the deductible ($175 Ind / $500 Fam), the plan pays per Schedule of Allowances After hospital-related medical expenses reach $3,000 per person, the plan pays 100% of reasonable and customary charges (as determined by GHI)	In-Network $10 copay Out-of-Network Per Schedule of Allowances, after deductible	In-Network $10 copay Out-of-Network Per Schedule of Allowances, after deductible	Covered for 75 days in full after $200 inpatient deductible ($500 annual maximum per person) Subject to penalty if not precertified by NYC Healthline	In-Network $10 copay, first prenatal visit only Out-of-Network **Physician:** per Schedule of Allowances, after deductible **Hospital:** Mother, $200 deductible; newborn nursery, $240 deductible
HIP Choice Plus	After the deductible ($250 Ind / $500 Fam), the plan pays 80% of reasonable charges After expenses reach $2,500 Ind / $7,000 Family, the plan pays 100% of reasonable charges	In-Network Covered in full Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network Hospital covered in full with prior approval; other services covered 80% after deductibles and coinsurance	In-Network Covered in full Out-of-Network Covered in full with prior approval
DC 37 Med-Team/ HealthEase	After the deductible ($350 Ind / $700 Fam), the plan pays 70% of the allowed amount as determined by DC 37 Med-Team/HealthEase After expenses reach $3,000 Ind / $9,000 Fam (excluding deductibles), the plan pays 100% of the allowed amount or the amount it would have paid a participating doctor	In-Network $10 copay Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network Deductibles and coinsurance	In-Network $100 copay ($300 annual max per family) Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network Deductibles and coinsurance
New York Life / Sanus Plus	After the deductible ($350 Ind / $1,000 Fam), the plan pays 75% of in-network allowable charges After expenses reach $2,500 Ind / $7,500 Fam, the plan pays 100% of in-network allowable charges	In-Network $5 copay Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network Deductibles and coinsurance	In-Network Covered in full Out-of-Network $200 copay per admission ($500 annual maximum)	In-Network Covered in full Out-of-Network $200 copay per admission ($500 annual maximum)
U.S. Healthcare Quality Point of Service	After the deductible ($250 Ind / $500 Fam), the plan pays 80% of reasonable and customary fees After expenses reach $2,500 Ind / $7,500 Fam, the plan pays 100% of reasonable and customary fees	In-Network $5 copay Out-of-Network Deductibles and coinsurance	In-Network $5 copay, PCP referral required Out-of-Network Deductibles and coinsurance	In-Network Covered in full, PCP referral required Out-of-Network Deductibles and coinsurance	In-Network $5 copay for OB/GYN visits, Hospital covered in full, PCP referral required Out-of-Network Deductibles and coinsurance

NOTE: In-network coverage applies only if care is provided or authorized by a participating physician.
Some plans require referral, authorization, or notification before the use of non-participating providers is covered.

COMPARISON OF POINT-OF-SERVICE (POS) PLAN
AND PREFERRED PROVIDER ORGANIZATION (PPO) / INDEMNITY PLAN BENEFITS
(Services Both In- and Out-of-Network)

	Emergency Room Care	Mental Health	Chemical Dependency	Optional Rider	Student Coverage
Empire Blue Cross Blue Shield BlueChoice POS	In-Network $35 copay, waived if admitted Out-of-Network Deductibles, coinsurance	In-Network **Inpatient:** Covered in full, 30 days/year **Outpatient:** 20 visits annually, $25 copay per visit Out-of-Network **Inpatient:** 30 days/year, deductible and 50% coinsurance **Outpatient:** 20 visits annually, deductible and 50% coinsurance	In-Network **Inpatient:** Covered in full 30 days rehab annually; 7 days detox annually **Outpatient**: Covered in full 60 visits/year Out-of-Network **Inpatient:** 30 days/year, deductible and 50% coinsurance **Outpatient:** 60 visits annually, deductible and 50% coinsurance	**Prescription Drugs:** Card plan with $5 generic copay (subscriber pays additional cost of brand name drugs); Mail order available in 100 unit supplies	Covered to age 23
GHI-CBP / Empire Blue Cross Blue Shield	$25 copay, waived if admitted	In-Network **Inpatient:** Covered in full 30 days/year **Outpatient:** 30 visits per year, $10 copay; 5 assessment visits covered in full. See Optional Rider. Out-of-Network **Inpatient:** 30 days per year at 50% of Network allowance **Outpatient:** Optional Rider Only	In-Network **Inpatient:** Detox, Rehab covered in full up to 30 days per year, 60 days per lifetime. See Optional Rider. **Outpatient:** 60 visits covered in full (combined with non-network visits); 5 assessment visits covered in full Out-of-Network **Inpatient:** Detox covered at average network allowance; Rehabilitation not covered. (See Optional Rider.) **Outpatient:** 60 visits at 75% of average Network allowance	**Prescription Drugs:** 20% generic coins. (40% brand), $150 Ind/$450 Fam deductibles, mail order; **Enhanced nonpar. provider schedule; Higher ann. max. reimbursement; Additional mental health and chemical dependency coverage; Students to age 23.**	Covered under Optional Rider only, to age 23
HIP Choice Plus	In-Network Covered in full Out-of-Network Covered in full ($50 charge if HIP not contacted)	In-Network **Inpatient:** Covered in full 30 days/year **Outpatient:** 20 visits to HIP Mental Health Center; $25 copay per visit Out-of-Network **Inpatient:** Covered in full up to 30 days per calendar year **Outpatient:** Covered 50% up to 20 visits (combined with in-network visits)	In-Network **Inpatient:** Covered in full, 30 day combined ann. max for drug/alcohol detox and rehab **Outpatient:** Covered in full, 60 visit combined ann. max for drug/alcohol treatment Out-of-Network **Inpatient:** Covered in full, 30 day combined ann. max for drug/alcohol detox and rehab **Outpatient:** Covered 80%, up to 60 visits (combined with in-network visits)	**Prescription Drugs:** covered in full from HIP providers at participating pharmacies; $10 copay from non-HIP providers at par pharmacies; scheduled benefit from nonpar pharmacies	Covered to age 23
DC 37 Med-Team/ HealthEase	$50 copay, waived if admitted	In-Network **Inpatient:** 30 days per year, $25 copay per day **Outpatient:** Not covered Out-of-Network **Inpatient:** Not covered **Outpatient:** Not covered	In-Network **Inpatient:** 30 days per calendar year (including mental and nervous inpatient days), $25 copay per day **Outpatient:** 60 visits/year, $10 copay/visit Out-of-Network **Inpatient:** Not covered **Outpatient:** Not covered	No Optional Rider. Additional benefits through DC 37 Health and Security Fund	Covered to age 23
New York Life / Sanus Plus	In-Network Covered in full Out-of-Network $50 copay, waived if admitted	In-Network **Inpatient:** Covered in full, 30 days combined ann. detox/mental health max **Outpatient:** 30 visits per year; #1-2 covered in full; #3-28, variable copays Out-of-Network **Inpatient:** Not cov. unless preapproved **Outpatient:** Not covered	In-Network **Inpatient:** Rehab covered up to 30 days per year; detox covered in full, 30 day combined annual max for detox and mental health **Outpatient:** 60 visits per year, $5 copay Out-of-Network **Inpatient:** 75% of network allowances **Outpatient:** Not covered	**Prescription Drugs:** $3 generic copay, $10 brand copay.	Covered to age 23
U. S. Healthcare Quality Point of Service	$35 copay, waived if admitted	In-Network **Inpatient:** Covered in full 35 days per 365 day period **Outpatient:** Covered for 20 visits per 365 day period, $25 copay per visit Out-of-Network **Inpatient:** 80% after deductible, 35 days per 365-day period **Outpatient:** 50% after deductible; 20 visits per 365-day period. $50,000 lifetime maximum for both in- and outpatient Out-of-Network benefits	In-Network **Inpatient:** Detox covered in full for acute phase of treatment; Rehab covered in full 30 days/year for alcohol and/or drug addiction **Outpatient:** $5 copay per visit; 60 visit combined max for drug and/or alcohol treatment per calendar year Out-of-Network **Inpatient:** Detox: 80% after deductible for acute treatment; Rehab: 80% after deductible; 30 days per year for alcohol/drug addiction **Outpatient:** 80% after deductible; 60-visit combined annual drug/alcohol treatment max	**Prescription Drugs:** $2.50 copay at participating pharmacies	Covered to age 23

HEALTH PLANS FOR MEDICARE ELIGIBLE RETIREES AND THEIR MEDICARE ELIGIBLE DEPENDENTS

There are several types of health plans offered to Medicare-eligible retirees and their Medicare-eligible dependents who are enrolled in both Medicare Part A and Part B. The programs include HMOs in which the enrollee must receive all health care services from the health plan; HMOs which allow access to non-network providers, but with only Medicare coverage applicable, and subject to Medicare deductibles, coinsurance and exclusions; and supplemental plans which allow for the use of any provider, and reimburse the subscriber who may be subject to Medicare or plan deductibles and coinsurance.

Recent Benefit Changes

Effective July 1, 1995

- **CAC-Ramsay** has changed its name to **CAC-United HealthCare**.
- **GHI/Empire Blue Cross Blue Shield Senior Care** has eliminated the $100 Part B deductible reimbursement for medical services, and implemented a hospital deductible of $200 per admission, with a $500 per person maximum each calendar year. These changes are for services rendered on or after July 1, 1995.
- **Physicians Health Services** has expanded its service area to include Bronx, Brooklyn, Queens, Manhattan, Staten Island, Nassau and Suffolk counties. The optional rider for prescription drugs will be increased from a $2000 maximum to unlimited prescription coverage.
- **U.S. Healthcare** has expanded its service area to Western and Central Pennsylvania which includes Armstrong, Lawrence, Cumberland, York, Dauphin, Lancaster, Perry and Schuylkill counties.

Effective August 1, 1995

- **CIGNA** in New York and New Jersey was no longer available to Medicare-eligible enrollees.
- **HIP/MCP** - a $10 copay for office visit or to an HIP After Hours Treatment Center and $200 copay for hospitalization up to a maximum of $500 per calendar year.

Effective October 1, 1995

- **Oxford Medicare Advantage** - Office visit copayments will increase from $4 to $10. Retirees in union welfare funds where prescription drugs are not covered will receive unlimited drug coverage with up to a $20 copayment for brand name drugs when no generic drug is available and up to a $10 copayment for generic drugs. If brand name drugs are purchased when there is an existing generic drug available, retirees will be charged the $10 copayment plus the difference in the cost of the brand name drug and the generic drug. The additional drug coverage will have a zero cost in New York and a cost of $43.80 per month per person in New Jersey.
- **U.S. Healthcare** will increase its copayment for physician office visits from $2 to $5. A $5 copayment will also be required for each referred visit to a participating specialist. A $10 copayment is required per prescription. The emergency room copayment will increase from $15 to $35; and all mental health visits will cost $25 per visit.

Effective January 1, 1996

- **DC 37 Med-Team/HealthEase** will eliminate the $100 Part B deductible reimbursement for medical services and will implement a hospital deductible of $200 per admission, with a $500 per person maximum each calendar year.
- **HIP VIP** will implement a $5 copayment for all office visits. There will be a $50 emergency room copay, which will be waived if an admission occurs. There will be a $25 copay per visit for outpatient mental health care. The per prescription drug copayment will be increased from $2.50 to $10. The unlimited prescription drug benefit will be reduced to a $500 maximum benefit per calendar year. Retirees in union welfare funds where prescription drugs are not covered will receive unlimited drug coverage. However, for such retirees there will be a $18.08 monthly pension deduction unless their union purchases the rider.
- **WellCare** will expand its service area to include Brooklyn, Broome, Bronx, Fulton, Manhattan, Montgomery, Otsego, Queens, Schoharie and Westchester counties in New York.

$200 MEDICAL EXPENSE REIMBURSEMENT TO CITY RETIREES

In order to further encourage participation in the Medicare HMO* plans, the City and the Municipal Unions are pleased to announce that retirees who are enrolled in any of the Medicare HMO plans will each be entitled to a $200 Medical Expense Reimbursement (to a maximum of $400 per contract if 2 or more Medicare-eligibles are enrolled) from the City if enrolled for a full benefit period of one year, in addition to the current Medicare Reimbursement. The program will begin in October 1995. The first payment will be made in July 1996 and will cover two quarters-October 1, 1995 through March 31, 1996. The retiree must be enrolled in the Medicare HMO plan on July 1, 1996 to qualify for any payment. Thereafter, retirees and eligible dependents will receive a full payment only if enrolled in an approved plan from April 1st through March 31st of the following year, subject to being enrolled the following July 1.

If a retiree is enrolled on the last day of a quarterly period (March 31st, June 30th, September 30th, December 31st), a payment of $50 will be credited for that quarter. If the retiree is not enrolled on the last day of the quarter, no payment will be provided for that quarter. Payment of the amounts credited for the coverage period (April through March) will occur in July provided the retiree is enrolled in the Medicare HMO plan on July 1.

If you qualify for the Medical Expense Reimbursement because of your enrollment in a Medicare HMO plan, you will be reimbursed automatically. No other action on your part is required.

* Enrollees in HIP VIP will not begin the Medical Expense Reimbursement Program until January 1, 1996.

The health plans listed below are the approved Medicare HMO plans. Approved Medicare HMO plans are those plans in which medical care is only provided by the HMO. Services, other than emergency services, rendered outside the plan are not reimbursable either by the HMO or by Medicare. A description of each of these plans can be found on the following pages in this section.

NEW YORK METROPOLITAN PLANS:

ChoiceCare (Nassau County Only)
Elderplan, Inc.
HIP VIP
Oxford Medicare Advantage
SANUS 65
U.S. Healthcare Medicare Plan

PLANS AVAILABLE OUTSIDE THE NEW YORK METROPOLITAN AREA:

*AvMed Medicare Plan (Call plan directly for information at 800-432-6676)
Blue Cross Blue Shield of Florida Health Options, Inc.
CIGNA HealthCare for Seniors
CAC-United HealthCare
HIP Medicare Advantage
PCA Qualicare
U.S. Healthcare Medicare Plan

* Late addition to Program. Plan description could not be provided for printing deadline.

Special Notes

- Medicare-Eligible Retiree premium costs (if any) for each plan are listed at the bottom of each plan description or on page 52.
- For Medicare-eligible retirees and their Medicare-eligible dependents, these health plans provide benefits similar to those described in each summary. For information about non-Medicare enrollee coverage, please refer to the health plans in Section Three I and II on pages 4 through 21.
- Medicare-eligible retirees should refer to page 47 "*CITY COVERAGE FOR MEDICARE-ELIGIBLE RETIREES*". This section contains additional information about Medicare enrollment rules, regulations, and guidelines.

Blue Cross Blue Shield of Florida
HEALTH OPTIONS
Independent Licensee of the Blue Cross and Blue Shield Association

Medicare & More
(Florida Residents)

Health Options®, Medicare and More, backed by Blue Cross and Blue Shield of Florida, is a federally qualified HMO with a Medicare contract. Medicare and More provides comprehensive, preventive health care coverage. In addition, you will pay no copayment except for emergency services and for the purchase of hearing aids. This plan is available to retirees who live in **Broward, Dade or Palm Beach Counties.**

Medicare and More coverage includes preventive care, unlimited hospital and doctor care, home health care, skilled nursing facility care, lab tests, X-rays, periodic health assessments, and prescription drugs.

When you enroll in Medicare and More, you select a Primary Care Physician (PCP) from our contracting network of health care providers. You can be assured that any care you receive is covered if it has been provided or arranged by your Primary Care Physician and there are virtually no claims to file.

The Primary Care Physician you choose will provide or arrange all of your routine health care, including referrals to Medicare and More specialists, when appropriate, and inpatient care at a Medicare and More hospital or skilled nursing facility, when necessary. Your Primary Care Physician coordinates your health care to ensure that you get the care that is right for you and to assist you in getting the most from your Medicare and More coverage. Should you need specialty care, your Primary Care physician will arrange it for you.

Except for emergencies anywhere and out-of-area urgent care, all care you receive must be obtained from the health care professionals and facilities in the Medicare and More provider network.

Prescription Drugs

Prescription drugs are included in the basic plan. There is no maximum and no copayments. There is a cost for non-Medicare enrollees if prescription drugs are not provided through their union welfare fund.

Cost

There is **no cost** for the basic plan for the Medicare enrollee. The costs for a non-Medicare eligible dependent(s) are on page 52.

For Additional Information

You may contact the plan at:

Blue Cross and Blue Shield of Florida, Inc.
Health Options, Inc.
3750 NW 87th Avenue, Suite 300
Miami, FL 33278-2415
(800) 999-6758

CAC-United HealthCare Plans of Florida, Inc.℠

Medicare Plus®

CAC - United HealthCare Plans of Florida is offering coverage to New York City retirees, when you have at least one Medicare eligible retiree in the family. Medicare eligible retirees may select Medicare Plus®, a federally qualified Medicare HMO which offers quality health care; a vast network of fully accredited primary care doctors and specialists right in your neighborhood; a wide selection of hospitals; and the strength of 25 years of managed care experience. Medicare Plus® offers coverage for preventive care, medical treatment, inpatient and outpatient hospital care, outpatient prescription drugs with no annual limit, worldwide emergency care, and more.

Medicare Plus® is available to City of New York retirees residing in **Dade, Broward, and Palm Beach counties**.

Non-Medicare eligible dependents can also receive coverage from CAC-United HealthCare's large selection of conveniently located physicians and hospitals.

CAC - United HealthCare Doctors

As members of CAC - United HealthCare's HMO plans, you and your family will receive coverage for services when you visit the carefully credentialed doctors and hospitals that participate in the CAC - United HMO. You must receive your treatment within the HMO network in order for that care to be covered.

Your Primary Care Physician may provide a referral to another participating physician who practices in the appropriate specialty. Your Primary Care Physician's referral is an important part of your care, and is necessary in order for your care to be covered.

With CAC - United HealthCare, you do not fill out claim forms or pay deductibles or coinsurance.

Prescription Drugs

Prescription drugs are included in the basic plan. There is no maximum and no copayments. There is a cost for non-Medicare enrollees if prescription drugs are not provided through their union welfare fund. The costs for a non-Medicare eligible dependent(s) are on page 52.

Cost

There is **no cost** for the basic plan.

For Additional Information

If you have any questions about Medicare Plus® , please call CAC - United HealthCare at **(800) 393-6500** or write to:

CAC-United HealthCare Plans
of Florida, Inc.
Group Medical Services
621 NW 53rd St., Suite 135
Boca Raton, FL 33487

ChoiceCare

ChoiceCare is available to New York City retirees who reside in **Nassau, Suffolk and Queens Counties.**

ChoiceCare Platinum
(Effective September 1, 1995 - Nassau County)

ChoiceCare Platinum participating physicians represent a select group of board certified Internists, Family Practitioners, and Specialists committed to meeting all your health care needs in the convenience of their private office. All you do is pay a $5 copayment for unlimited office visits. ChoiceCare medically necessary, unlimited hospital stays covered at 100% and dental, vision, and hearing benefits are also included in the plan. Medically necessary emergency care is covered around the clock anywhere in the world. ChoiceCare is also available for guidance on emergency care 24 hours a day 7 days a week. When specialty services are needed, your Primary Care Physician will provide you with a referral to the necessary specialty care. All routine examinations, mammography, and pap tests are covered for a $5 office visit copay.

As part of the basic plan up to $500 of prescription drug coverage is provided per year. There is a $5 copay for generic drugs and a $10 copay for brand named prescriptions. If you have coverage through your welfare fund, the first $500 will be paid by ChoiceCare.

City of New York Medicare retirees who do not receive prescription drug coverage through their Welfare Fund will receive coverage as provided: generic drugs for a copay of $5; brand-name drugs for a copay of $10; a maximum of $5,000 per year. The cost is **$31.38** monthly per person.

Medical care received outside the plan is not covered by the plan or Medicare, except in an emergency situation.

ChoiceCare Medicare
(Suffolk & Queens County)

This plan offers all of the benefits described under the ChoiceCare Platinum Program. The plan covers the deductibles, coinsurance and services not covered by Medicare. In order to be covered up to plan limits, Medicare-eligible members must use ChoiceCare physicians. If a non-participating physician is used, only Medicare coverage is applicable and care is subject to deductibles, coinsurance and exclusions.

ChoiceCare Medicare offers an additional optional rider for prescription drug coverage that is accepted at over 90% of the pharmacies in the United States. See ChoiceCare's medical directory for a complete listing of tri-county area pharmacies. There is a $7 copay per prescription (brand and generic) after an annual $50 per person deductible has been met; there is no annual limit.

Cost

All plan costs are noted on page 52.

For Additional Information

To speak with a representative, call ChoiceCare at **(800) 330-6418**, Monday through Friday, 8:30 a.m. to 5:30 p.m.

Corporate Center
395 North Service Road
Melville, New York 11747-3127

CIGNA HealthCare

CIGNA HealthCare for Seniors is available to retirees living in in **Southern California; Phoenix or Tucson, Arizona; Albuquerque, New Mexico; and Denver, Colorado.**

Effective August 1, 1995 CIGNA in New York and New Jersey was no longer available to Medicare-eligible enrollees.

If you are a retiree with Medicare Parts A and B coverages, you are eligible to join the CIGNA HealthCare for Seniors program. This program provides benefits more comprehensive (the program includes prescription drugs, unlimited hospital days, preventive care, and worldwide emergency care coverage) than Medicare Parts A and B. The deductibles and coinsurances associated with Medicare Parts A and B are eliminated and replaced with low copayments and no deductibles.

All non-emergency care must be coordinated by your CIGNA HealthCare Primary Care Physician. CIGNA HealthCare for Seniors will not pay for services provided by a non-participating provider unless approved in advance by CIGNA HealthCare.

A prescription drug benefit is included in the basic plan as follows:

LA and San Diego, CA	$ 2,500 maximum with $5 copay
Albuquerque, N M	$ 500 maximum with $12 copay
Denver, CO	$ 400 maximum with $10 copay
Phoenix , AZ	$ 750 maximum with $7 copay
Tucson, AZ	$ 1,000 maximum with $7 copay

Cost

There is **no cost** for the basic plan.

For Additional Information

For more detailed information on this benefit program, please call the appropriate office.

CALIFORNIA	
L.A. and San Diego	**(800) 441-1981 ext. 15**
NEW MEXICO (Lovelace)	
Albuquerque	**(800) 262 -3757**
COLORADO	
Denver	**(800) 863-6668**
ARIZONA	
Phoenix and Tucson	**(800) 572-9990**

EMPIRE BLUECROSS BLUESHIELD

Supplemental Medicare Plan

Available only to DC 37 members, retirees, and their families, DC 37 Med-Team/HealthEase offers a full range of coverage, all provided within local communities where members live or work.

The DC 37 Med-Team/HealthEase program offers a supplemental plan offered through Empire Blue Cross Blue Shield for Medicare-eligible retirees. For example, if you're hospitalized because you need surgery, the plan's hospital coverage combined with Medicare Part A provides benefits for room, board, general nursing, and other hospital services. The plan's medical coverage, with Medicare Part B, provides benefits for physician services and supplies. While Medicare Parts A and B cover hospital and medical care, most benefits are subject to deductibles or coinsurance. Empire's Medicare Supplemental plan helps retirees with Medicare Parts A and B avoid out-of-pocket costs by reimbursing most of these deductible and coinsurance amounts with the following exceptions: a $200 per admission deductible, with a $500 per person maximum each calendar year and the Medicare Part B deductible of $100 annually.

Prescription drugs are covered by DC 37.

Cost

There is **no cost** for this plan.

For Additional Information

If you have questions or would like additional information, please call our member service representatives at **800-342-9741** from 8:30 a.m. to 4:45 p.m. any business day. When you call, please identify yourself as a DC 37 member.

You may write to the plan at:

DC 37
125 Barclay Street - 3rd Floor
New York, New York 10007

ELDERPLAN, INC. SM

The Health Plan for Seniors

Elderplan is a pre-paid health plan which serves the needs of Medicare-eligible residents of **Brooklyn**. We are sponsored by Metropolitan Jewish Health Care System, one of the region's most respected managed care organizations.

Elderplan protects the health of older adults by emphasizing prevention (for example, by teaching you how to stay healthy and encouraging regular checkups), early detection of medical problems and prompt treatment. Members choose their Elderplan physician from our selected provider list. All of our doctors specialize in geriatric medicine.

There is no monthly premium with Elderplan coverage. You can choose your own doctor from our medical group. Everything you may need, from your personal Elderplan doctor to specialists, hospital care, prescription medicines is available near your home.

If you need a specialist who is not in the Elderplan medical group, your doctor will make the final decision to refer you to an appropriate specialist in the area. You will be covered in full. Hospital services are provided at Maimonides, Victory Memorial, Lutheran and Kings Highway Hospitals. If you require specialty care which is not available at these member hospitals, your Elderplan doctor will refer you to another hospital and your care will be covered in full.

Emergency care is covered in full if it is delivered in your area. When out-of-area, there is a $50 copayment for emergency care.

Drugs prescribed by your Elderplan doctor are subject to a $2 copayment when ordered by mail and a $5 copayment at member pharmacies. There is no annual limit. Medical transportation, including an ambulance for medical emergencies and car service to and from your doctor and other providers, is also covered.

Additional Services and Supplies

Routine foot care ($2 copayment per visit); eye exams; eyeglasses ($10 a pair every two years); hearing exams; hearing aids ($40 per aid every 2 years); durable medical equipment; prosthetic devices; routine dental care; dentures ($100 per set every 3 years).

Chronic Care Benefits

If you become chronically disabled and your condition requires it, Elderplan will coordinate a total plan of care. This includes services in your home, in the community, or in a long term care facility. In-home and community care includes nursing visits; physical, occupational and speech therapy; homemaker, housekeeper, personal care and chore services; adult day care; in-home respite; home-delivered meals; and electronic monitoring.

Cost

There is **no cost** for this plan.

For Additional Information

You are encouraged to call our Enrollment Services Department with questions between the hours of 9:00 a.m. to 5:00 p.m. at **(718) 921-7898**. Or write to:

Elderplan, Inc.
6323 7th Avenue,
Brooklyn, NY 11220

BLUECHOICE®

EMPIRE BLUECROSS BLUESHIELD

GHI
The good news in health care.℠

BlueChoice Medicare Supplement

This Medicare Supplement plan offers Medicare-eligible retirees protection from costly health care by filling the gaps in Medicare coverage. While Medicare Parts A and B cover hospital and medical care, most benefits are subject to deductibles or coinsurance. Empire's Medicare Supplement plan helps retirees with Medicare Parts A and B avoid out-of-pocket costs by reimbursing most of these deductible and coinsurance amounts with the following exceptions: a $200 per admission deductible, with a $500 per person maximum each calendar year and the current Medicare Part B deductible of $100 annually.

For example, if you're hospitalized because you need surgery, the plan's hospital coverage combined with Medicare Part A provides benefits for room, board, general nursing, and other hospital services. The plan's medical coverage, with Medicare Part B, provides benefits for physician services and supplies.

Optional Rider

Empire offers an optional rider for prescription drug coverage. You can use your prescription drug card at over 4,100 Empire Network Pharmacies throughout the tri-state area. Present your card and prescription to the pharmacist. You then pay either the $5 copay for each prescription or the pharmacy's customary charge, whichever is less. If you need prescription medication on a regular or long-term basis, you can also order up to a 100 unit supply through the mail service program, subject to the $5 copay. You must pay any additional charges if you or your provider request a brand-name drug.

Cost

There is **no cost** for the basic plan.
The cost for the optional rider is on page 52.

For Additional Information

To keep you informed, Empire has staffed the **Dedicated Service Center** with customer service representatives specially trained to explain the program. If you would like additional information about the program during open enrollment, please call **800-767-8672 or 212-476-7666.** For your convenience, telephone hours are from 8:30 a.m. to 5:30 p.m., Monday through Fridays.

You may contact the plan at:

Empire Blue Cross Blue Shield
City of New York Dedicated Service Center
P.O. Box 4883 Grand Central Station
New York, New York 10163

Senior Care

If you are a Medicare-eligible retiree enrolled in either GHI-CBP/EBCBS or GHI Type C/EBCBS, Senior Care supplements your Medicare coverage. Senior Care supplements Medicare for home and office visits, surgery and anesthesia, dental surgery, in-hospital medical care, radiation therapy, specialist consultations, diagnostic procedures, X-ray examinations, laboratory tests, and shock therapy; also intermittent nurse service (Visiting Nurse Service) in your home. Medicare pays 80% of the Medicare-scheduled allowance, and Senior Care pays the remaining 20% for services both in and out of the hospital after a $100 deductible.

If you are a Medicare-eligible retiree, GHI/EBCBS Senior Care is available to supplement Medicare. Under Senior Care, Empire will supplement your Medicare coverage for inpatient hospital service, and will pay the Medicare Part A inpatient deductible less a $200 deductible per admission (maximum $500 per year).

Optional Riders

From GHI: Prescription drug coverage from TelePAID pharmacies (subject to deductibles and coinsurance, $2,500 maximum benefit); maintenance drug coverage (subject to $8 copay for generic and $10 copay for brand name drugs, maximum 60-day supply).

From EBCBS: 365-day hospital coverage.

Cost

There is **no cost** for the basic plan. The costs for the optional riders is on page 52.

For Additional Information

You may contact:

Group Health Incorporated
441 Ninth Avenue
New York, NY 10001
(212) 501-4444

Empire Blue Cross Blue Shield
City of New York Dedicated Service Center
P.O. Box 4883
Grand Central Station
New York, New York 10163
(800) 767-8672 or (212) 476-7666

NEW YORK • NEW JERSEY • FLORIDA
HIP
HEALTH INSURANCE PLAN OF GREATER NEW YORK

HIP VIP

(Effective January 1, 1996 - New York & New Jersey)

If you are a City of New York retiree and you or your spouse are enrolled in Medicare Parts A and B, HIP VIP is the plan for you. You receive all the benefits provided by Medicare, plus all of these additional benefits provided by HIP:

Coverage for prescription eyeglasses: (In NY - every 24 months from a special selection) (In NJ - up to $70 reimbursement every 2 years); in-hospital private-duty nursing when ordered by an HIP affiliated physician; up to $300 (up to $400 in NJ) towards the purchase of a hearing aid every 3 years; preventive dental care; and certain prosthetic devices and appliances. There is a $5 copayment for office visits.

With HIP VIP, you and your family members choose a family physician practicing at one of HIP's 56 multispecialty medical centers. Or you may choose an HIP affiliated physician practicing in his or her own office as part of our expanding network of neighborhood physicians. Your physician will refer you to appropriate specialists for treatment and services whenever necessary.

You may visit your family physician - and female members may visit the gynecologist - as often as necessary without charge. You are covered for routine examinations, medical screenings, and emergency care, as well as routine foot care and preventive dental care, which includes two examinations and one cleaning a year. Mental health services are available at HIP Mental Health Centers.

HIP Medical Centers provide a wide range of comprehensive medical services including routine lab, X-ray, mammography and sonography services, along with highly specialized laser, nuclear and fiber optic diagnostic services. Many of these services are offered right in our medical centers.

Any medical care, except for covered emergencies or urgently needed care out of the area that is neither provided by or authorized by HIP, will not be covered by either HIP or Medicare.

Prescription Drugs

There is a $10 copayment per prescription (up to a $500 annual maximum) for prescription drugs prescribed by your HIP affiliated physician and obtained through any one of HIP's 1,600 participating pharmacies. If your union welfare fund does not provide drug coverage you will have the following: prescription drug coverage with a $5 copayment ($10 in New Jersey) per prescription at a participating pharmacy. The monthly cost for this benefit is **$18.08** in New York per person; and **$31.36** in New Jersey per person.

Cost

There is **no cost** for the basic plan.

For Additional Information

In New York you may call **1-800-HIP-NYC9.**
In New Jersey you may call **1-800-794-3442.**

NEW YORK • NEW JERSEY • FLORIDA
HIP
HEALTH INSURANCE PLAN OF GREATER NEW YORK

HIP Medicare Advantage

(Effective July 1, 1995 - Southeast Florida)

HIP Medicare Advantage is a full medical and hospitalization plan for residents of **Dade, Broward and Palm Beach** counties enrolled in Medicare Parts A and B. It offers all the benefits of Medicare without deductibles, plus coverage for important services not covered or limited in coverage by Medicare. These include unlimited prescription drug coverage, with no copayment, physical exams, eye exams and hearing tests, routine foot care, immunizations, even eyeglasses every 12 months and hearing aids up to $300 every 3 years. There is no charge for office visits.

You choose a physician from HIP's affiliated provider network of over 1,000 physicians. Your primary care physician coordinates your care and will refer you to specialists when necessary.

Members must obtain all medical and hospital services through HIP of Florida's network of participating physicians and affiliated hospitals. When visiting HIP's other service areas in New York and New Jersey, members can receive full benefits including routine care, through the HIP Interplan program.

Cost

There is **no cost** for this plan.

For Additional Information

You may call the plan at 1-**800-826-1013.**

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HIP Medicare Advantage

(Effective September 1, 1995 - Tampa Bay Area)

If you live in Pinellas, Hillsborough, Pasco and Hernando Counties, you can join HIP Medicare Advantage. HIP Medicare Advantage is a full medical and hospitalization plan for those enrolled in Medicare Parts A and B. It offers all the benefits of Medicare without deductibles, plus coverage for services not covered by Medicare. Prescription drugs are covered up to $1,200 per calendar year with a $5 copay for generic drugs (if brand name drug requested, retiree pays the difference in the cost between the generic and the brand name drug); one pair of eyeglasses per calendar year and up to $300 for hearing aids.

Any medical care, except for covered emergencies or urgently needed care out of the area that is neither provided by or authorized by HIP, will not be covered by either HIP or Medicare.

Cost

There is **no cost** for this plan.

For Additional Information

You may call the plan at **1-800-826-1013.**

Oxford Medicare Advantage

More Than Medicare. HumanCare℠

If you are eligible for Medicare Parts A and B and live in the **five boroughs of New York City, Nassau, Rockland, Suffolk and Westchester in New York and Bergen, Essex and Passaic counties in New Jersey** then you can be a part of Oxford Medicare Advantage, a Medicare contracted Health Maintenance Organization. Oxford Medicare Advantage offers you a comprehensive health plan with no deductibles, and virtually no paperwork.

Freedom to Choose Your Doctor

When you join Oxford you have the freedom to choose your personal doctor from our list of highly-credentialed Private-Practice Physicians. The doctor you choose will become your Primary Care Physician and will work with you to coordinate all of your healthcare needs, including referrals to specialists and admissions to hospitals. Doctor visits are only $10 and your annual physical is free. As an Oxford Member, you'll receive full coverage for hospitalization when arranged or authorized by your Primary Care Physician. And, in the case of an emergency, Oxford Members are covered anywhere in the world.

Preventative Care

Oxford encourages its Members to take care of themselves which is why you are entitled to a free annual physical, free annual dental checkups (with discounted dental care), free yearly mammograms and Pap smears for women, as well as vision and hearing aid benefits.

Prescription Drugs

New York residents will receive prescription drug coverage with a $5 generic/$10 brand name copayment ($500 annual maximum). **For New Jersey residents, there is no basic drug plan.**

Retirees in union welfare funds where prescription drugs are not covered will receive unlimited drug coverage with up to a $20 copayment for brand name drugs when no generic drug is available and up to a $10 copayment for generic drugs. If brand name drugs are purchased when there is an existing generic drug available, retirees will be charged the $10 copayment plus the difference in the cost of the brand name drug and the generic drug. There is **no cost** for the plan in New York. For New Jersey residents the monthly cost is **$43.80** per person.

If your welfare fund offers prescription benefits, you will continue to receive the benefit through your fund.

Cost

There is **no cost** for the basic plan.

For Additional Information

If you have any questions about Oxford Medicare Advantage, please us call today at **800-277-4134, Ext. 793** , Monday - Friday, 9:00 a.m. - 5:00 p.m. Please identify yourself as a City of New York Retiree.

PCA QualiCare™

PCA Health Plans of Florida

PCA QualiCare is offered by PCA Health Plans of Florida, Inc. to retirees on Medicare in the counties of **Dade, Broward and Palm Beach, in South Florida; and the counties of Manatee, Hillsborough, Pinellas, Pasco, Seminole, Orange, Osceola, Duval, Clay, Nassau, and Baker in North and Central Florida.**

PCA QualiCare covers all of your medically necessary care while you are in the hospital. That includes surgery, lab tests, X-rays - virtually everything - and there is no limit when authorized by your PCA QualiCare physician. PCA QualiCare covers visits to your PCA QualiCare doctor. You will be covered for physical exams, lab tests, immunizations, and almost anything you are likely to need. World-wide emergency care is also provided. You will not be charged for paying deductibles because you will be charged only for small copayments (if any), you will not pay coinsurance, and you will not have any paperwork (claim forms) to file.

To enroll in PCA QualiCare you must be on Medicare Parts A and B. You must select a physician from the listing you receive from PCA QualiCare and all of your medical care must be handled and approved by your PCA QualiCare physician. PCA QualiCare and Medicare will not pay for unapproved medical care charges that are not a result of a life threatening emergency.

PCA QualiCare requires that you reside in the counties mentioned above for most of the year. If you plan to travel out of the service area for more than three consecutive months you must disenroll from PCA QualiCare. You may change to another PCA QualiCare region in Florida if you plan to reside there for an extended time (see counties above). Only emergency care would be covered if you travel out of the service area for any length of time.

Prescription Drugs
(At Participating Pharmacies)

South Florida: No copayment and no maximum for Medicare-eligibles.

North/Central Florida: Medicare-eligible retirees who do not receive prescription coverage through their Welfare Fund will receive unlimited prescription coverage with no copayment. Retirees who receive drug coverage through the Welfare Fund are entitled to prescription coverage with no copayment ($1000 annual maximum).

All Areas (Non-Medicare enrollees): Enrollees who do not receive prescription drug coverage through their Welfare Fund will receive unlimited prescription coverage with a $5 generic/$15 brand copayment. The cost for this benefit is on page 52.

Cost

There is **no cost** for the basic plan or prescription drugs for the Medicare-eligible retiree. The cost for the basic plan for non-Medicare eligible dependent(s) is on page 52.

For Additional Information

For more details on benefits you may call one of the "800" telephone numbers for your region. **Tampa office: (800) 303-0909; Orlando office: (800) 925-3705; Jacksonville office: (800) 884-9910; Miami office: (800) 888-1012; Boca Raton office: (800)365-1808.** A qualified member services representative will help you with your questions and arrange an appointment with a PCA QualiCare representative to help you fill out your enrollment papers. Please identify yourself as a City of New York Retiree.

Physicians HEALTH SERVICES

Physician's Health Services

The PHS Medicare programs are available to retirees living in the **Bronx, Brooklyn, Queens, Manhattan, Staten Island, and Nassau, Suffolk, Westchester, Putnam, Rockland, Orange, Dutchess counties and the state of Connecticut.**

Medicare Plan
(New York Residents)

The PHS/NY Retirement Plan is designed to work with Medicare, where PHS helps pay for many of the services Medicare does not cover in full. To qualify, you must be enrolled in Medicare Parts A & B as of July 1, 1995. To be covered in full, Medicare eligibles must use PHS physicians. PHS covers Medicare hospital and medical deductibles and coinsurance amounts in full. In addition, the plan pays for services that Medicare doesn't cover at all, such as annual physical exams, mammography screenings and pap smears. PHS picks up all "excess" charges beyond the Medicare-approved amount, which means virtually no balance billing or additional costs. If a non-participating physician is used, only Medicare coverage is applicable and care is subject to deductibles, coinsurance and exclusions.

PHS/CT Carefree
(Connecticut Residents)

The PHS/Carefree program provides comprehensive medical and hospital benefits to City of New York retirees enrolled in Parts A&B of Medicare. To be covered in full, Medicare eligibles must use PHS physicians. This special plan is designed to work with Medicare and includes all of the Medicare-covered services and more. PHS/Carefree pays for things that Medicare doesn't, such as: Medicare deductibles for office visits (less a $5 copay) and hospitalizations, physical exams, mammography screenings according to age schedule, immunizations, and worldwide emergency care (less a $25 copay). PHS processes Part B services directly - all claims come only to PHS for full payment, less any applicable copayments. If a non-participating physician is used, only Medicare coverage is applicable and care is subject to deductibles, coinsurance and exclusions.

Prescription Drugs

An optional rider is available to retirees which covers prescription drugs, subject to a $10 copayment per prescription with no limit. Mail order is also available, subject to a $10 copayment for a 90 day supply.

Cost

All plan costs are noted on page 52.

For Additional Information

If you have any questions about any aspect of the PHS program, please call PHS toll-free at **800-441-5741**, 8:30 a.m. to 5:00 p.m., Monday through Friday.

Crosswest Office Center, Suite 212
399 Knollwood Road
White Plains, NY 10603

NEW YORK LIFE S A N U S℠

EMPLOYEE BENEFIT PLANS

New York Life/Sanus Medicare

New York Life/Sanus Plus serves **New York City, Nassau, Suffolk, Westchester, Putnam, Orange and Rockland counties in New York; and the entire State of New Jersey.**

New York Life/Sanus Plus is available to retirees living in **Houston and Dallas/ Ft. Worth, Texas; St. Louis, Missouri; and the Washington, D.C. area.** While the plan benefits in these locations are similar to the benefits offered in New York, there are some differences in copayments and deductibles. More information can be obtained by calling **800-4NY-SANUS (800-469-7268).**

This plan includes coverage for the deductibles, coinsurance, and services not covered by Medicare Parts A & B, but will not exceed the coverage provided through the standard Sanus Plus plan. To be covered in full, Medicare members must use New York Life/ Sanus participating physicians.

Prescription Drugs

An optional prescription drug program is available as follows: generic drugs for a copy of $3 with no deductible; brand-name drugs for a copay of $10 with no deductible.

Cost

The cost for the basic plan and optional rider are on page 52.

New York Life/Sanus 65
(Nassau, Suffolk and Queens Only)

If you are retired, living in **Nassau, Suffolk or Queens** and you have Medicare Part A and B, you are eligible for the Sanus 65 Health Plan. There is no premium for this program. All Medicare benefits are covered, plus more.... transportation to and from your physician's office; $500 yearly prescription benefit with $3 copayment for generic or $10 copayment for name brand prescriptions; no charge for physician visits; unlimited covered hospital days with no deductible; worldwide emergency and urgent care. The copayment for the emergency room is $50 which is waived if you are admitted to the hospital. When you join Sanus 65 you choose a Primary Care Physician from a list of network providers who will manage your care. You cannot go outside the network unless you are authorized or you have an emergency. More information about this plan can be obtained by calling **800-SANUS 65 (800 -726-8765).**

Cost

There is **no cost** for the Sanus 65 program.

For Additional Information

You can contact the plans at:

New York Life/Sanus Health Plan
75-20 Astoria Blvd.
Jackson Heights, NY 11370

US HEALTHCARE

The U.S. Healthcare Medicare Plan is available to retirees living in the **New York City region (the five boroughs and following counties: Nassau, Orange, Putnam, Rockland, Suffolk, and Westchester), the entire states of New Jersey and Connecticut; Pennsylvania (the metropolitan areas of Allentown, Harrisburg, Lancaster, Philadelphia, Pittsburgh and Reading); Delaware, Massachusetts, New Hampshire, Maryland and Washington D.C.**

Each U.S. Healthcare member selects a participating Primary Care Physician who is an internist or a family doctor. Additionally, each female member can select a participating gynecologist for routine gynecological care. All routine and preventive care received in the participating Primary Care Physician's office is covered with a $5 copayment.

Members are entitled up to a $70 reimbursement for prescription glasses or contact lenses every 24 months, and are eligible for up to a $500 allowance toward the purchase or repair of a hearing aid every 36 months.

U.S. Healthcare's Medicare Plan also includes a preventive dental program. For a $2 copay at the participating dentist you select, you will receive a routine cleaning and examination. Additional dental work is available at reduced fees.

Specialty care, hospitalization, surgery, intensive care, ambulance service, physical or rehabilitation therapy, skilled nursing care, home care, allergy treatments, hearing examinations, anesthesia, diagnostic tests and X -rays are fully covered when your participating Primary Care Physician refers you to a network specialist or hospital for a covered service. There is a $5 copay, when you visit specialists that are referred by your participating Primary Care Physician. Emergency care is covered anytime, anywhere in the world.

You must obtain a referral from your participating Primary Care Physician for specialty and hospital care. Medical and hospital care received outside the U.S. Healthcare network is not covered by U.S. Healthcare or Medicare, unless approved in advance by U.S. Healthcare or in an emergency situation.

Prescription Drugs

Retirees who do not receive prescription coverage through their Welfare Fund will receive unlimited prescription coverage at a $10 copayment per prescription. The cost for this coverage is noted on page 52.

Retirees who receive drug coverage through their Union Welfare Fund are also entitled to the basic prescription coverage at a $10 copayment ($500 annual maximum) within their respective service area.

Cost

There is **no cost** for the basic plan.

For Additional Information

Please call **800-282-5366** for the current Medicare Primary Care Physician listing and more detailed information on U.S. Healthcare's Medicare benefits. Customer service representatives are available to answer your questions 8 a.m. to 7 p.m., Monday through Friday, and 9 a.m. to 3 p.m. on Saturday. You can also send your questions in writing to:

U.S. Healthcare
1425 Union Meeting Road
Blue Bell, PA, 19422
Attention: Solutions Department.

WellCare™ of NEW YORK, Inc.

This plan is open to retirees residing in the counties of **Albany, Brooklyn, Broome, Bronx, Columbia, Delaware, Dutchess, Fulton, Greene, Manhattan, Montgomery, Orange, Otsego, Putnam, Queens, Rensselaer, Rockland, Saratoga, Schenectady, Schoharie, Sullivan, Ulster, Warren, Washington, and Westchester in New York.**

If you are retired with both Medicare Parts A and B, you are also eligible for WellCare. This plan provides the same comprehensive benefits of the standard WellCare program, and includes coverage for deductibles, coinsurance, and services not covered by Medicare Parts A and B, but not to exceed the standard coverage provided through WellCare's program. To be covered in full, Medicare-eligibles must use WellCare physicians. If a non-WellCare physician is used, only Medicare coverage is applicable and treatment is subject to deductibles, copayments, and exclusions.

A prescription drug benefit, requiring a $3 copayment per prescription at a participating pharmacy is included in the basic plan. Prescriptions will be dispensed on a generic basis. Those members requesting a brand-name drug must pay the difference between the brand name drug and the generic drug whenever a generic drug is available, plus the $3 copay.

Cost

The plan cost is noted on page 52.

For Additional Information

Employees or retirees who have questions about this coverage may contact the WellCare Member Services Department at the telephone numbers below. You may contact the plan at:

Executive Woods
4 Palisades Drive
Albany, NY 12205
(518) 446-0200

130 Meadow Avenue
Newburgh, New York 12550
(914) 566-0700

120 Wood Road
Kingston, New York 12401
(914) 334-4000

15 North Mill Street
Nyack, N.Y. 10960
(914) 353-1281

22 Riverside Drive
Carriage House
Binghamton, New York 13905
(607) 724-0050

440 Park Avenue South
New York, New York 10016
(212) 779-3900

During the New York City Transfer Period, specially trained representatives will be available Monday to Friday 8:00 a.m. to 8:00 p.m. at **(800) 288-5441** or **(914) 566-7047 (TDD only)** or you may contact one of our local Service Centers.

Comparison of Health Plan Benefits for Medicare Enrollees
NEW YORK METROPOLITAN AREA PLANS

	Eligible for $200 Annual Bonus?	Choice of Providers	Medicare Part B $100 Deductible	Office Visit / Outpatient Care	Outpatient Testing (X-rays, labs, etc.)	Inpatient Hospital Care (room & board, surgery, anesthesia, other hospital services
ChoiceCare Platinum (Nassau County) **	Yes	Network providers only	Covered through plan	$5 copay	$5 copay	Covered in full
ChoiceCare Medicare * (Suffolk and Queens Counties)	No	Any provider (Medicare coverage only for non-network providers)	Covered through plan	$5 copay	Covered in full	Covered in full
Elderplan ** (Brooklyn)	Yes	Network providers only	Covered through plan	Covered in full	Covered in full	Covered in full
Empire BlueChoice Medicare Supplement	No	Any provider	Not covered through plan; deductible applies	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	Reimburses Part A hospital deductible: 365 days, $200 deductible per admission ($500 max)
GHI/EBCBS SeniorCare (Nationwide)	No	Any provider	Not covered through plan; deductible applies	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	Reimburses Part A hospital deductible. First 60 days covered after $200 deductible per admission ($500 max); next 180 days partially covered. Optional Rider increases coverage to 365 days in full.
HIP VIP ** (NY, NJ only)	Starting January 1996	Network providers only	Covered through plan	Covered in full ($5 copay starting 1/1/96)	Covered in full ($5 copay starting 1/1/96)	Covered in full
DC 37 Med-Team/ HealthEase Medicare Supplement	No	Any provider	Not covered through plan; deductible applies	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	Reimburses Part A hospital deductible: 365 days, $200 deductible per admission, $500 max
SANUS Medicare *	No	Any provider (Medicare coverage only for non-network providers)	Covered through plan	$5 copay	Covered in full	Covered in full
SANUS 65 ** (Nassau, Suffolk, Queens Only)	Yes	Network providers only	Covered through plan	Covered in full	Covered in full	Covered in full
Oxford Medicare Advantage **	Yes	Network providers only	Covered through plan	$10 copay	Covered in full	Covered in full
Physicians Health Services/Carefree * (CT) Physicians Health Services/NY	No	Any provider (Medicare coverage only for non-network providers)	Covered through plan	CT: $5 copay NY: Covered in full	Covered in full	Covered in full
US Healthcare Medicare **	Yes	Network providers only	Covered through plan	$5 copay	$5 copay	Covered in full
WellCare *	No	Any provider (Medicare coverage only for non-network providers)	Covered through plan	Covered in full ($5 copay starting 1/1/96)	Covered in full	Covered in full

* Coverage levels indicated apply only if care is provided or authorized by a participating physician.
If a non-participating physician is used, only Medicare benefits apply; Medicare deductibles, coinsurance, and exclusions are in effect.

** Coverage levels indicated apply only if care is provided or authorized by a participating physician.
Except for emergencies, neither the health plan nor Medicare will pay for services rendered outside of the plan.

Comparison of Health Plan Benefits for Medicare Enrollees
NEW YORK METROPOLITAN AREA PLANS

	Private-Duty Nursing	Mental Health	Prescription Drugs	Additional Benefits
ChoiceCare Platinum (Nassau County) **	Covered in full when medically necessary	Inpatient: Covered in full, 190 day lifetime maximum Outpatient: $5 office visit copay	$500 benefit ($5,000 if no welfare fund coverage), $5 generic copay, $10 brand	Dental, vision, and hearing benefits
ChoiceCare Medicare* (Suffolk and Queens Counties Only)	Covered in full when medically necessary	Inpatient: Covered in full 30 days Outpatient: 20 visits/year;#1-3, $5 copay, #4-20, $25 copay	Optional Rider: Unlimited benefit; $7 copay after $50 deductible	
Elderplan ** (Brooklyn)	80% of charges, maximum 30 shifts annually	Inpatient: Covered in full, 190-day lifetime maximum Outpatient: $5 copay	Unlimited benefit; formulary list; $5 copay ($2 copay by mail)	Dental, vision, hearing, transportation, routine foot care, and chronic care benefits
Empire BlueChoice Medicare Supplement	80% after the first 72 hours when authorized by a physician; $100 deductible	Inpatient: Covered in full, 190-day lifetime maximum Outpatient: Reimburses 20% of amount approved by Medicare	Optional Rider: Select Network, $5 copay (mandatory generic), mail order available	
GHI/EBCBS SeniorCare (Nationwide)	80%, subject to $25 deductible, $2,500 maximum benefit per person	Inpatient: Covered in full, 190-day lifetime maximum Outpatient: Not Covered	Optional Rider: $2,500 benefit, deductibles ($150 Ind/$450 Fam), coinsurance (20% generic/40% brand); mail order ($8 generic / $15 brand copays) 60-day supply	
HIP VIP ** (NY, NJ only)	Covered in full when authorized by HIP	Inpatient: Covered in full; Outpatient: $25 per visit	$10 copay per 30-day supply ($500 annual maximum as of 1/1/96)	Dental, vision, and hearing benefits
DC 37 Med-Team/ HealthEase Medicare Supplement	80% after the first 72 hours when authorized by a physician; $100 deductible	Inpatient: Covered in full, 190-day lifetime maximum Outpatient: Reimburses 20% of amount approved by Medicare	Available through DC 37 Health and Security Plan	
SANUS Medicare *	Covered in full when medically necessary	Inpatient: Covered 30 days Outpatient: 20 visits per year, 50% copay, when authorized	Optional Rider: $3 generic copay ($10 brand); no deductible	
SANUS 65 ** (Nassau, Suffolk, Queens Only)	Covered in full when medically necessary and ordered by PCP	Inpatient: Covered in full, 190 day lifetime maximum Outpatient: Covered in full	$500 benefit; $3 generic copay, $10 brand copay	Transportation to and from doctor's office
Oxford Medicare Advantage **	Not covered	Inpatient: Covered in full up to 190 day lifetime maximum Outpatient: 50% of Medicare approved charges	$500 benefit and $5 generic copay, $10 brand copay if welfare fund coverage exists; otherwise unlimited benefit, $10/$20 copay	Dental, vision, and hearing benefits
Physicians Health Services/Carefree * (CT) **Physicians Health Services/NY**	Covered in full when medically necessary and approved by PHS	Inpatient: Hospital covered in full (psychiatric facility covered in full, 190-day lifetime maximum) Outpatient: Covered in full	Optional Rider: Unlimited benefit; $10 copay, no deductible; 90 day mail order supplies	
US Healthcare Medicare **	Covered in full when medically necessary	Inpatient: Covered in full, 190 day lifetime maximum Outpatient: $25 copay	$500 benefit, $10 copay if welfare fund coverage exists; otherwise unlimited benefit	Dental, vision, and hearing benefits
WellCare *	Covered in full	Inpatient: Covered in full, 30-day annual maximum Outpatient: 20 visits/year;#1-5, $5 copay, #6-20, $10 copay	$3 copay	

Comparison of Health Plan Benefits for Medicare Enrollees

OUTSIDE THE NEW YORK METROPOLITAN AREA

	Eligible for $200 Annual Bonus?	Medicare Part B $100 Deductible	Office Visit / Outpatient Care	Outpatient Testing (X-rays, labs, etc.)	Inpatient Hospital Care (room & board, surgery, anesthesia, other hospital services)
Blue Cross & Blue Shield of Florida, Inc. Health Options "Medicare and More" ** (Florida's Broward, Dade, and Palm Beach Counties)	Yes	Covered through plan	Covered in full	Covered in full	Covered in full
CAC-United Healthcare ("Medicare Plus") ** (Florida's Dade, Broward, and Palm Beach Counties)	Yes	Covered through plan	Covered in full	Covered in full	Covered in full
CIGNA HealthCare for Seniors ** (CA, NM, AZ, CO)	Yes	Covered through plan	CA: $5; NM $12; Phoenix,AZ: $10 Tucson, AZ: $5 CO: $10;	Covered in full	Covered in full
GHI/EBCBS SeniorCare (Nationwide)	No	Not covered through plan; deductible applies	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	Reimburses Part A hospital deductible. First 60 days covered after $200 deductible per admission ($500 max); next 180 days partially covered. Optional Rider increases coverage to 365 days in full.
HIP Medicare Advantage ** (Florida's Dade, Broward, Palm Beach Counties, and the Tampa Bay area)	Yes	Covered through plan	Covered in full ($5 copay, Tampa Bay area)	Covered in full	Covered in full
DC 37 Med-Team/HealthEase Medicare Supplement	No	Not covered through plan; deductible applies	Reimburses 20% of amount approved by Medicare	Reimburses 20% of amount approved by Medicare	Reimburses Part A hospital deductible: 365 days, $200 deductible per admission ($500 max)
New York Life/Sanus Medicare * (Houston and Dallas/ Ft. Worth, TX; St. Louis, MO; Washington, DC)	No	Covered through plan	Covered in full	Covered in full	Covered in full
PCA QualiCare ** (South, Central, and North Florida)	Yes	Covered through plan	Varies by area, from covered in full, to $10 copay	Varies by area, from covered in full, to $10 copay	Covered in full
U.S. Healthcare Medicare ** (PA, DE, MA, NH, MD, DC)	Yes	Covered through plan	$5 copay	$5 copay	Covered in full

* Coverage levels indicated apply only if care is provided or authorized by a participating physician. If a non-participating physician is used, only Medicare benefits apply; Medicare deductibles, coinsurance payments, and exclusions are in effect.

** Coverage levels indicated apply only if care is provided or authorized by a participating physician. Except for emergencies, neither the health plan nor Medicare will pay for services rendered outside of the plan.

Comparison of Health Plan Benefits for Medicare Enrollees

OUTSIDE THE NEW YORK METROPOLITAN AREA

	Private-Duty Nursing	Mental Health	Prescription Drugs	Additional Benefits
Blue Cross & Blue Shield of Florida, Inc. Health Options "Medicare and More" ** **(Florida's Broward, Dade, and Palm Beach Counties)**	Covered in full when ordered by PCP and medically necessary	Inpatient: Covered in full, 190 day lifetime max Outpatient: Covered in full	Unlimited benefit, no deductible. Generic covered in full; you must pay difference in cost for brand drugs if generic available	Dental, vision, and hearing benefits
CAC-United Healthcare ** ("Medicare Plus") **(Florida's Broward, Dade, and Palm Beach Counties)**	Covered in full when medically necessary	Inpatient: Covered in full, 190 day lifetime maximum Outpatient: Covered in full	Unlimited benefit, covered in full	Dental, vision, hearing, routine foot care, and transportation benefits
CIGNA HealthCare for Seniors ** **(CA, NM, AZ, CO)**	Covered in full when medically necessary	Inpatient: Covered in full, 190-day lifetime maximum Outpatient: Covered in full	Benefits vary by location; see page 27	
GHI/EBCBS SeniorCare **(Nationwide)**	80%, subject to $25 deductible, $2,500 annual benefit maximum per person	Inpatient: Covered in full, 190-day lifetime maximum Outpatient: Not covered	Optional Rider: $2,500 benefit, deductibles ($150 Ind/$450 Fam), coinsurance (20% generic/40% brand); mail order ($8 generic / $15 brand copays) 60-day supply	
HIP Medicare Advantage ** **(Florida's Dade, Broward, Palm Beach Counties, and the Tampa Bay area)**	Covered in full when authorized	Inpatient: Covered in full Outpatient: Covered in full (In Tampa Bay area, $5 copay)	Covered in full (In Tampa Bay area, $1,200 annual benefit, $5 generic copay)	Dental (except Tampa Bay area), and routine foot care benefits
DC 37 Med-Team/ HealthEase Medicare Supplement	80% after the first 72 hours when authorized; $100 deductible'	Inpatient: Covered in full, 190-day lifetime maximum Outpatient: Reimburses 20% of amount approved by Medicare	Available through DC 37 Health and Security Plan	
New York Life/Sanus Medicare * **(Houston and Dallas/Ft. Worth, TX; St. Louis, MO; Washington, DC)**	Covered in full when medically necessary	Inpatient: 30 days covered in full Outpatient: 20 visits per year, 50% coinsurance	$3 copay for generics, $10 copay for brands. no deductible	Dental and vision benefits
PCA QualiCare ** **(South, Central, and North Florida)**	Covered in full when medically necessary	Inpatient: Covered in full, 190 day lifetime max Outpatient: $20 copay per visit	Benefits vary by location; see page 31	Dental, vision, routine foot care, and transportation benefits
U.S. Healthcare Medicare ** **(PA, DE, MA, NH, MD, DC)**	Covered in full when medically necessary	Inpatient: Covered in full, 190 day lifetime max Outpatient: $25 copay	$10 copay ($500 benefit for those with welfare fund coverage; unlimited coverage for those without; benefits differ in PA and MA)	Dental, vision, and hearing benefits

SECTION FOUR
GENERAL INFORMATION
ENROLLMENT

A. Cost to Enrollees

Under the City's Health Benefits Program, the basic coverage under some of the health plans requires no member contribution, while others require a payroll or pension deduction. All plans, except for DC 37 Med-Team/HealthEase, offer additional benefits through Optional Riders which may be purchased through payroll or pension deductions. Basic plan and Optional Rider costs are shown on pages 50 - 52 of this booklet.

Under the voluntary Medical Spending Conversion (MSC) Premium Conversion Program, employee health plan deductions are made on a pre-tax basis (see Medical Spending Conversion, C. page 39).

B. Eligibility

1. Employees

You are eligible for health coverage and you may enroll in the Health Benefits Program if:

a. You work—on a regular schedule — at least 20 hours per week; and

b. Your appointment is expected to last for more than six months.

2. Retirees

You are eligible for health coverage and you may enroll in the Health Benefits Program when you retire if you meet *all* of the following criteria:

a. You have, at the time of retirement, at least five years of credited service as a member of a retirement or pension system maintained by the City (this requirement does not apply if you retire because of accidental disability); and

b. You have been employed by the City immediately prior to retirement, as a member of such system, and have worked regularly for at least 20 hours per week; and

c. You receive a pension check from a retirement system maintained by the City.

EXCEPTIONS: Members of pension systems not maintained by the City may be eligible for health coverage pursuant to legislation or a collective bargaining agreement specifying such coverage.

3. Dependents Eligible for Enrollment

a. Legally married husband or wife. An ex-spouse is never eligible for coverage under the Health Benefits Program regardless of the provisions of any legal settlement.

b. A 'domestic partner', defined as a person, eighteen years of age or older, who is not married or related by blood to the employee or retiree in a manner that would bar marriage in the State of New York, who has a close and committed personal relationship with the employee or retiree, who lives with the employee or retiree and has been living with same on a continuous basis, and who, together with the employee or retiree, has registered as a domestic partner of the employee or retiree and has not terminated the domestic partnership. Employees can obtain details concerning eligibility, enrollment, and tax consequences from the agency payroll or personnel office or from the Office of Labor Relations, Domestic Partnership Liaison Unit at 212-306-7336. Retirees should call 212-513-0470 for information.

c. Unmarried children under age 19. The term "children" for purposes of this and the following definitions, includes: natural children; children for whom a court has accepted a consent to adopt and for the support of whom an employee or retiree has entered into an agreement; children for whom a court of law has made an employee or retiree legally responsible for support and maintenance; and children who live with an employee or retiree in a regular parent/child relationship and are supported by the employee or retiree.

d. Unmarried dependent children age 19 to 23 who are full-time students.* Unmarried children under the age of 19 are eligible for health benefits under the basic plan coverage. The coverage termination date for children reaching age 19 will be the end of the payroll period during which the child reached age 19.

Health benefits coverage for qualified full-time students, who are covered either through basic coverage or an optional rider, will be available to age 23 at a minimum. The coverage termination date will be the end of the calendar year (December 31) of the student's 23rd birthday or graduation, whichever occurs first. Qualifying criteria for coverage (see below) must be met for each term attended.

All of the following criteria must be met for coverage of dependent children over age 19:

Full-time (as determined by the educational institution), unmarried, dependent students under the age of 23 are covered if the employee or retiree has a family contract.

- The student must be enrolled in an educational institution accredited in the state in which it is situated.
- The institution must grant a degree or diploma.
- The employee or retiree must supply at least 50% of the student's support and the student must be listed as a covered dependent under the City health plan.

Students, age 19 and over, if qualified, will be covered through the end of the last term in which they qualify. The spring term will be assumed to extend until the first day of the fall term. The fall term will be assumed to extend until the first day of the spring term. The terms are to be as determined by the respective institutions. If the student does not qualify for a term, coverage will be terminated effective the last day of the prior term, as defined.

If a qualified student has a temporary medical disability (determined by the health plan based upon acceptable medical documentation) and cannot complete a term, the student

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* WellCare provides full-time student coverage to age 25. Hospital coverage for full-time students is not available under GHI Type C/EBCBS.

disability continues into the next term (again, acceptable medical documentation required), the student will continue to be covered for up to one year from the original date of disability. Thereafter, COBRA or a direct payment conversion contract will be available. If s/he is permanently disabled (determined by the health plan based upon acceptable medical documentation) prior to reaching the date upon which eligibility would cease without disability, the student can be covered indefinitely by being added to the employee's or retiree's contract as a disabled dependent. If the student applies for COBRA after receiving coverage under a temporary medical disability, the eligible COBRA period will be reduced by the length of the period of coverage provided during the disability.

e. Unmarried children who cannot support themselves because of mental illness, developmental disability, mental retardation, or physical handicap, if the disability occurred before the age at which coverage would otherwise terminate, and the dependent was covered by the City at that time. In order to maintain continuous coverage, you must provide medical evidence of the disability to your health plan within 31 days of the date the dependent reaches the age limitation. Contact your health plan or agency personnel or payroll office for the forms which must be completed for continuation of coverage.

4. Double City Coverage Is Not Permitted

You cannot be covered by two health contracts for which the City pays or to which the City contributes.

If you are eligible for coverage as an employee or retiree AND as a dependent (of another City employee or retiree), you may enroll as an employee (or retiree) or as a dependent, but not both. Eligible dependent children must all be enrolled as dependents of one parent.

If both husband and wife, or domestic partner, are eligible for City health coverage as either employees or retirees and one is enrolled as the dependent of the other, the person enrolled as a dependent may pick up coverage, at any time, in his or her own name if the other contract is terminated for any reason.

C. Medical Spending Conversion (MSC) and Health Care Flexible Spending Account (HCFSA)

MSC is comprised of two distinct programs: the Premium Conversion Program and the Health Benefits Buy-Out Waiver Program.

Premium Conversion Program

The Premium Conversion Program allows all New York City employees who are eligible to receive City health benefits and who make payments for basic and/or optional benefits to have their health plan deductions taken from their paycheck on a pre-tax basis and thereby increase their take-home pay. The pre-tax deduction effectively reduces the salary on which taxes are computed by the amount of the health plan deduction. The increase in take-home pay will depend on the health plan, rider choice, and whether there is individual or family coverage. The overall reduction in gross salary is shown on the Form W-2 at the end of the year, but no change is reflected in the gross salary amount on employees' paychecks.

Enrollment

All City employees who have payroll deductions for health benefits are automatically enrolled in the Premium Conversion Program unless they decline enrollment at the time they become eligible for health plan coverage or during the Transfer Period. Employees who have no payroll deductions for health benefits are not considered participants in the Premium Conversion Program. A newly hired employee who does not want to participate in the Premium Conversion Program may decline participation by obtaining an MSC Form from his/her agency benefits office and submitting it together with the Health Benefits Application (Form ERB 95) to the MSC Administrative Office.

Changes in Enrollment Status

Because of the tax advantages provided, the program is strictly regulated by the Internal Revenue Service (IRS). Most important among the IRS guidelines is the requirement that an employee who participates or declines participation in the Premium Conversion Program must continue that participation status for an entire Plan Year unless a mid-year Qualifying Event occurs and the employee wishes to change the participation status at that time. If a mid-year Qualifying Event occurs, employees will have 31 days from the date of the Qualifying Event to submit an MSC Form with the required documentation to their benefits officer in order to request a change. Otherwise, they must wait until the Transfer Period to submit the request.

A change in health plan status which results in a change in payroll deductions may only be made during the Transfer Period, or within 31 days of an employee's experiencing a Qualifying Event.

Qualifying Events:

- A change in family status such as marriage, divorce, or legal separation between participant and spouse; or
- The death of a spouse or dependent; or
- The birth or adoption of a child which will be the participant's dependent; or
- The attainment of the maximum age for coverage of a dependent child; or
- A recently divorced participant is required under court order to provide health insurance coverage for eligible dependent children; or
- Choice of another health plan (e.g. resulting from a move out of an HMO service area); or
- A change in title which necessitates a change in health plan; or
- The termination of participant's employment for any reason including retirement; or
- A change in spouse's coverage which is significant and outside the spouse's control (e.g. benefit reduction); or
- A spouse's employment status change (such as the termination or the commencement of employment) resulting in a health insurance coverage change (either acquiring or losing eligibility for coverage); or

- A change in the participant's or spouse's employment status from part-time to full-time, or vice versa, resulting in a health insurance coverage change ; or
- The taking of an approved unpaid leave of absence by the participant or the spouse; or
- An increase in the employee's health plan deduction by more than 20%; or
- Such other events as may be determined to be appropriate and in accordance with applicable regulations.

Employees Who Have Previously Waived or Cancelled Health Benefits Coverage

An employee who is eligible for health benefits coverage, but who has previously waived or cancelled such coverage, may reinstate health benefits subject to the waiting period described in Reinstatement of Coverage, page 44. Such reinstatement of coverage will normally be on a pre-tax basis (unless the employee completes an MSC Form declining Premium Conversion Program participation). Reinstatement of coverage is only possible

1) within 31 days of a Qualifying Event (see listing above); or
2) during the Transfer Period.

Effect of Premium Conversion Program on Health Benefits Program Rules and Procedures

The IRS rules require that for an employee covered by the Premium Conversion Program, payroll deductions for health benefits coverage remain the same for the entire plan year. Therefore, no status change can be made which results in a change in the amount of an employee's health plan deduction unless a Qualifying Event has occurred. As a result, the following health plan changes can only be made **within 31 days of a Qualifying Event or during the annual Transfer Period:**

- Change from family to individual coverage while an employee's dependents are still eligible for coverage.
- Change from individual to family coverage if an individual's dependents were previously eligible for coverage.
- Voluntary cancellation of coverage or the dropping of an Optional Rider while an employee is still eligible for such coverage or rider.

Health Benefits Buy-Out Waiver Program

The Health Benefits Buy-Out Waiver Program allows all New York City employees who are eligible to receive City health benefits to waive their New York City Health Benefits in return for a cash incentive payment if they are covered under a spouse's or domestic partner's health plan, through another employer, or through Medicare Parts A & B. Employees with family coverage who waive City health benefits will receive $1,000 annually, and employees with individual coverage who waive City health benefits will receive $500 annually. The incentive payments are taxable to the employee.

Enrollment

To enroll in the Health Benefits Buy-Out Waiver Program, the employee must complete **both** the MSC Form and the Health Benefits Application (Form ERB 95) and submit them to his/her agency benefits office during the annual Transfer Period. A newly hired employee must complete and submit the MSC Form and the Health Benefits Application (Form ERB 95) within 31 days of becoming eligible to receive City health benefits in order to enroll in the program.

Changes in Enrollment Status

As with the Premium Conversion Program, an employee who participates in the Health Benefits Buy-Out Waiver Program must continue that participation status for an entire Plan Year unless a mid-year Qualifying Event occurs and the employee wishes to change participation status at that time. If a mid-year Qualifying Event occurs, employees will have 31 days from the date of the Qualifying Event to submit an MSC Form and the Health Benefits Application (Form ERB 95) with the required documentation to their benefits officer in order to request a change. Otherwise, they must wait until the annual Transfer Period to submit the request.

Qualifying Events:

- A change in family status such as marriage, divorce or legal separation between participant and spouse; or
- The death of a spouse or dependent; or
- The birth or adoption of a child which will be the participant's dependent; or
- A recently divorced participant is required under court order to provide health insurance coverage for eligible dependent children; or
- The termination of participant's employment for any reason including retirement; or
- A change in spouse's coverage which is significant and outside the spouse's control (e.g. benefit reduction); or
- A spouse's employment status change (such as the termination or the commencement of employment) resulting in a health insurance coverage change (either acquiring or losing eligibility for coverage); or
- A change in the participant's or spouse's employment status from part-time to full-time, or vice versa, resulting in a health insurance coverage change; or
- The taking of an approved unpaid leave of absence by the participant or the spouse; or
- Such other events as may be determined to be appropriate and in accordance with applicable regulations.

Employees Who Return to Payroll Following Leave Without Pay (LWOP)

An employee who is on leave without pay during the Transfer Period is entitled to elect the MSC upon return to payroll. If the employee wants to participate in the Premium Conversion Program, enrollment is automatic. If the employee does not want to participate in the Premium Conversion Program, an MSC Form must be completed. If the employee wants to participate in the Health Benefits Buy-Out Waiver Program, the employee must complete **both** the MSC Form and the Health Benefits Application (Form ERB 95).

An employee who goes on LWOP after the beginning of the year and subsequently returns to payroll during the same year is not entitled to a new MSC election unless a Qualifying Event has occurred. The election in effect at the beginning of the Plan Year will continue until a change is made on an MSC Form during the Transfer Period or upon the occurrence of a Qualifying Event.

Health Care Flexible Spending Account (HCFSA)

On January 1, 1994 the City instituted a Health Care Flexible Spending Accounts Program to help you pay for necessary medical expenses not covered by your health, dental or vision insurance. Your account is funded through pre-tax payroll deductions, effectively reducing the participant's taxable income. After incurring an Eligible Medical Expense, a claim is submitted to the plan office, and a reimbursement check is issued from the Flexible Spending Account. This reimbursement check you receive is never subject to federal income tax or social security tax (FICA). While the tax savings can be considerable, it will depend on your income tax bracket and the amount of your contribution. For more information, please contact your benefits manager or call the Program's Administrative Office at (212) 306-7760.

D. How to Enroll For Health Benefits

1. As an Employee

To enroll, you must obtain and file a Health Benefits Application (Form ERB 95) at your payroll or personnel office. The form must be filed within 31 days of your appointment date (for exceptions, see F.). If you do not file the form on time, the start of your coverage will be delayed and you may be subject to loss of benefits.

Effective April 1, 1994, new employees or employees enrolling for the first time are required to provide acceptable documentation to support the eligibility status of ***all*** persons to be covered on their City health plan coverage.

2. At Retirement

You must file a Health Benefits Application (Form ERB 95) at your payroll or personnel office prior to retirement to continue your coverage into retirement.

3. After Retirement

To enroll, you must obtain a Health Benefits Application (Form ERB 95) from the Health Benefits Program. Complete the form and file it with the Health Benefits Program. You must meet the eligibility requirements for health benefits coverage. If you are retired from a cultural institution, library, or the Fashion Institute of Technology, or if you receive a TIAA/CREF pension and are eligible for City health coverage, you must file a Health Benefits Application (Form ERB 95) with your former employer.

4. Deferred Retirement

As the result of a collective bargaining agreement, retirees who are members of the New York City Employees' Retirement System -- Pension Plan A -- or the Board of Education Retirement System and have had at least 20 years of credited service are eligible for five years of additional City coverage. If you have retired but will not receive a City pension check until age 55, you may be eligible for up to an additional five years of City-paid health benefits coverage. Please contact your payroll or personnel office for details.

E. Waiver of Health Benefits

If you are already enrolled for City health benefits in any other capacity (for example, as a dependent), or if you do not want City health coverage, you must waive membership in the Health Benefits Program by completing the appropriate sections of the Health Benefits Application (Form ERB 95). Every eligible employee or retiree must either enroll for coverage or waive membership. (See Buy-Out Waiver Program, page 40).

If you have waived membership and subsequently wish to enroll for City health plan coverage, you may be subject to a waiting period (see F. 6.).

F. Effective Dates of Coverage

1. When Coverage Begins for Employees

For Provisional employees, Temporary employees, and those Non-Competitive employees for whom there is no experience or education requirement for employment, coverage begins on the first day of the pay period following the completion of 90 days of continuous employment, provided that your Application (Form ERB 95) has been submitted within that period.

2. For All Other Employees

For employees appointed from Civil Service lists, Exempt employees, and those Non-Competitive employees for whom there is an experience or education requirement, coverage begins on your appointment date, provided your Application (Form ERB 95) has been received by your agency personnel or payroll office within 31 days of that date.

3. For Eligible Dependents

Coverage for eligible dependents listed on your Application (Form ERB 95) will begin on the day that you become covered.

Dependents acquired after you submit your Application (Form ERB 95) as a result of marriage, domestic partnership, birth, or adoption, will be covered from the date of marriage, domestic partnership, birth or adoption, provided that you submit the required notification and documentation within 31 days of the event (see Changes in Family Status, A., page 43).

4. Late Enrollment

For employees, retirees, and their dependents, filing an application later than 31 days after the date of the marriage, birth, etc. constitutes a late enrollment. Coverage will begin on the first day of the payroll period following the receipt of the application (for retirees, the first day of the month following the submission of a ERB 95) by the agency payroll or personnel office.

Participation in the Medical Spending Conversion (MSC) Program may limit health plan enrollment and/or status changes. If such changes affect your health plan deductions, they must be made within 31 days of the Qualifying Event or they cannot be made at all until the next Transfer Period (see Medical Spending Conversion, page 39).

5. When Coverage Begins for Retirees

If you file the Health Benefits Application (Form ERB 95) for continuation of coverage into retirement with your agency payroll or personnel office prior to retirement (usually 4 to 6 weeks), for most retirees, coverage begins on the day of retirement (see G., Identification Cards).

6. If you have waived or cancelled your City health plan coverage and subsequently wish to enroll or reinstate your benefits, your coverage will not start until the beginning of the first payroll period 90 days following the date you submit your Application (Form ERB 95), unless the enrollment or reinstatement is the result of a loss of other group coverage.

G. Identification Cards

When you first enroll under the Program, whenever there is a change in family status (for example, from individual to family), when you transfer from one plan to another, or when you retire, your health plan(s) will issue new identification cards.

Group Health Incorporated/Empire Blue Cross and Blue Shield subscribers (GHI Type C/EBCBS or GHI-CBP/EBCBS) will receive two identification cards, a GHI card and an Empire Blue Cross and Blue Shield card. The EBCBS card should be used for hospital admissions or emergency room visits, and the GHI card should be used for physician or other medical services.

If you do not receive a new identification card from your health plan within three months after submitting an Application (Form ERB 95), you should notify your agency payroll or personnel office. If you are a retiree, write to the Health Benefits Program (see Section One).

Between submission of a retirement application and the issuance of the new identification cards, retirees may receive cancellation notices and notice of direct payment options from the plan. You should ignore this mailing, as it is due to a routine delay in updating computer files to reflect retirement status.

If the retiree or any of his/her dependents, enrolled in an HMO or POS, need services and the identification cards have not been issued, the retiree should present the retiree copy of the Application (Form ERB 95) to the physician as proof of enrollment. If the retiree belongs to an indemnity program, claims should be held and submitted after the identification cards are received. If hospitalized, the retiree should contact his/her health plan or the Health Benefits Program for assistance.

H. Optional Riders

All health plans, except DC 37 Med-Team/HealthEase have an Optional Rider consisting of benefits which are not part of the basic plan. You may elect Optional Rider coverage when you enroll. Optional Riders are paid for through payroll or pension deductions. The cost of these riders can be found on pages 50-52.

Many employees and retirees get additional health benefits through their welfare funds. If you are enrolled in a health plan with multiple benefits in the optional rider, and your welfare fund is providing benefits similar to some (or all) of the benefits in your plan's Optional Rider, those specific benefits will be provided only by your welfare fund and will not be available through your health plan rider. Pension and payroll deductions will be adjusted accordingly. Each rider is a package. You may not select individual benefits in the rider.

If the Optional Rider consists only of a prescription drug plan, and your union welfare fund provides prescription drug benefits, you should not choose the Optional Rider because payroll or pension deductions will not be adjusted automatically to account for union welfare fund benefits.

For Medicare HMO plans, prescription drug benefits may be automatically included in your plan benefits.

I. Deductions for Basic Coverage and Optional Riders

1. From Paychecks

If there is a payroll deduction for your plan's basic coverage, or if you apply for an Optional Rider, your paycheck should show a deduction for this cost. If your check does not reflect the deduction within two months after submitting a new Application (Form ERB 95), or if your deductions are not correct, you must notify your personnel or payroll office.

2. From Pension Checks

It may take considerable time before health plan deductions start from retirees' pension checks. A large retroactive deduction is then made to pay for coverage during the period from retirement to the time of the first deduction.

When retirees in the New York City Employees' Retirement System receive their first full pension allowance checks, their pension numbers change. Because of this, deductions will stop for three to five months and will begin again when the new numbers have been processed. Health coverage is continuous throughout this period. When deductions resume, they will include back charges for months when deductions were not taken. Contact the New York City Health Benefits Program if deductions are incorrect. When either you or a dependent becomes eligible for Medicare (by reaching age 65 OR through disability), the amount deducted is adjusted after you notify the Health Benefits Program of Medicare coverage (see City Coverage for Medicare - Eligible Retirees, page 47). This adjustment may also take time to be recorded.

3. Incorrect Deductions

If incorrect deductions are being taken from your payroll or pension checks, you ***must*** report the error within 31 days. Employees must contact their agency benefits representative and retirees must contact the Health Benefits Program. Corrections will be made as quickly as possible after notification.

CHANGES IN ENROLLMENT STATUS

A. *Changes in Family Status*

Changes in your family status may make it necessary, or desirable, for you to change your type of coverage. Changes in coverage do not happen automatically. You must submit a form requesting the type of change you wish to make. Employees may obtain a Health Benefits Application (Form ERB 95) and submit the completed form to their personnel or payroll office. Retirees should obtain the Application (Form ERB 95) and submit the completed form to the Health Benefits Program.

1. Adding or Dropping Dependents

You must complete the Form ERB 95 to add dependents due to marriage, domestic partnership, birth or adoption of a child, and to drop dependents due to death, divorce, termination of domestic partnership, or a child reaching an ineligible age or losing full-time student status*. Forms must be submitted within 31 days of the event (see page 42, Late Enrollment). Appropriate documentation of marital status, domestic partnership, or birth or adoption of a child is required. This documentation may consist of marriage or birth certificate; adoption or guardianship papers; or copies of tax returns indicating a child is claimed as a dependent. Domestic partner documentation must consist of a completed Declaration of Financial Interdependence accompanied by two items of proof evidencing financial interdependence (non-New York City residents must complete an "Alternative Affidavit of Domestic Partner").

B. *Change in Plan*

1. Annual Transfer Period

Health Benefits Transfer Periods are usually scheduled once each year. During these periods, all employees may transfer from their current health plan to any other plan for which they are eligible, or they may add or drop Optional Rider coverage to their present plan. Retirees participate in Transfer Periods that occur in even-numbered years.

If you do not apply for an Optional Rider when you first enroll, you may add these additional benefits only during a Transfer Period, upon retirement, or if there is a change in your union or welfare fund coverage.

NOTE: The 1995 Transfer Period will take place from October 2, to October 31, 1995 and will be open to employees only.

All transfer applications must be submitted by October 31, 1995. Changes made by employees will become effective the first full payroll period in January 1996.

Procedures for Employee Health Plan Transfers

In order to transfer from one plan to another or to add Optional Rider coverage, you must complete a Health Benefits Application (Form ERB 95), which is available from your agency payroll or personnel office. This form must be completed and returned to your payroll or personnel office during the annual Transfer Period.

See your agency payroll or personnel office for the effective date of the change. Once you submit an Application (Form ERB 95), the Transfer Period is over for you and your transfer is irrevocable.

2. Retiree Transfer Opportunities

As a result of collective bargaining, retirees may transfer or add an Optional Rider during the even-numbered year Transfer Periods. Additionally, retirees may transfer or add an optional rider once in their lifetime, at any time after they have been retired for at least one year. Once-in-a-lifetime transfers become effective on the first of the month following the date that the retiree signs the Health Benefits Application (Form ERB 95).**

C. *Transfer Into or Out of Your Health Plan's Service Area*

If you permanently move outside of your plan's service area, you may transfer within 31 days to another plan without waiting for the next Transfer Period. Also, if you move into the service area of a plan, you may transfer within 31 days to that plan.**

D. *Leave of Absence Coverage*

Special Leave of Absence Coverage (SLOAC)

Certain employees authorized leave without pay as a result of temporary disability, disability or illness due to pregnancy or illness, or who are receiving Workers' Compensation, may have their City health coverage continued for certain specified periods of time through the SLOAC provisions. Contact your payroll or personnel office for details.

Family and Medical Leave Act (FMLA)

The Federal Family and Medical Leave Act of 1993 ("FMLA") entitles eligible City employees to twelve weeks of family leave in a 12-month period to care for a dependent child or covered family member, and for the serious illness of the employee. Employees using this leave may be able to continue their City health coverage through the FMLA provisions for unpaid leave. Contact your payroll or personnel office for details.

E. *Change of Address*

If you change your address be sure to notify your health plan and your agency so that your records can be kept up-to-date. Always provide your certificate or identification number when communicating with health plans.

Retirees should notify the Health Benefits Program of any address change.

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* If a covered dependent loses eligibility, that person may obtain benefits through the COBRA Continuation of Benefits provisions described on page 45.

** Exception: When transferring into a Medicare HMO plan other than during Transfer Periods, transfers will become effective on the first day of the second month following the date of authorization indicated on the Form ERB 95. (For example, if the ERB 95 is completed in August, the effective date would be October 1.)

F. Transfer from One City Agency to Another

If you leave the employment of one City agency at which you are covered under the City's Health Benefits Program, and subsequently become employed by another City agency at which you are eligible to enroll for health coverage, your coverage will become effective on your appointment date at the new agency, provided that no more than 90 days have elapsed since your coverage terminated at the first agency. Your new agency should reinstate your coverage by submitting a completed Health Benefits Application (Form ERB 95) (See Termination and Reinstatement, B.) You may only change health plans during the annual Transfer Period.

If more than 90 days have elapsed, the Effective Dates of Coverage rules specified on page 41 apply. You must complete a new Health Benefits Application (Form ERB 95).

G. Change of Union or Welfare Fund Membership

Title changes that result in a change of union or welfare fund membership may require a change in payroll deductions for any Optional Rider coverage. You must contact your agency benefits representative within 31 days if you have changed unions or welfare funds.

TERMINATION AND REINSTATEMENT

A. When Coverage Terminates

Coverage terminates:

- for an employee or retiree and covered dependents, when the employee or retiree stops receiving a paycheck or pension check (with an exception for people eligible for SLOAC or FMLA).
- for a spouse, when divorced from an employee or retiree.
- for domestic partner, when partnership terminates.
- for a child, upon marriage or reaching an ineligible age, except for unmarried dependent full-time students who are covered on all plans* up to age 23 or 25. (See page 39, B.3.e. for special provisions for disabled children who reach age 19, 23 or 25.)
- for all dependents, unless otherwise eligible, when the City employee or retiree dies.

If both husband and wife, or domestic partner, are eligible for City health coverage as either an employee or a retiree, and one is enrolled as the dependent of the other, the person enrolled as dependent may pick up coverage in his/her own name within 31 days of the spouse or domestic partner leaving City employment or death.

B. Reinstatement of Coverage

If you have been on approved leave without pay, or have been removed from active pay status for any other reason, your health coverage may have been interrupted.

Contact your agency benefits representative within 31 days of your return to duty in order to complete a new Health Benefits Application (Form ERB 95). If you are returning from an approved leave of absence or your coverage has been terminated for less than 90 days, coverage resumes on the date you return to duty. If you were not on an approved leave of absence or if your coverage has been terminated for more than 90 days, the effective date of coverage rules specified in on page 41 apply.

If you have waived or cancelled your City health plan coverage and subsequently wish to enroll or reinstate your benefits, your coverage will not start until the beginning of the first payroll period 90 days following the date you submit your Application (Form ERB 95) unless the enrollment or reinstatement is the result of a loss of other group coverage.

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*Empire Blue Cross and Blue Shield hospital coverage is available only through the Optional Rider under GHI-CBP/EBCBS, and is not available under GHI Type C/EBCBS. GHI medical coverage for full-time students is only available through the Optional Rider under GHI-CBP/EBCBS.

OPTIONS AVAILABLE WHEN CITY COVERAGE TERMINATES

A. Conversion Option

Employees and/or their spouses, or domestic partners, and covered dependents may purchase health coverage through their plan on an individual, self-paid basis when coverage under the City's group plan ceases. Unlike COBRA (discussed below), benefits under this type of policy do not automatically terminate after a limited time, and may vary from the City's "basic" benefits package in both the scope of benefits and in cost.

An employee, and covered dependents may convert to a direct-payment policy when coverage under the City's group plan ceases for any of the following reasons:

- an employee leaves City employment;
- an employee loses City coverage due to a reduction in the work schedule;
- the employee or retiree dies;
- a dependent spouse is divorced from the employee or retiree;
- the domestic partnership terminates;
- dependent children exceed the age limits established under the group contract; or
- coverage under the provisions of COBRA expires (see below for further information).

B. COBRA Continuation Benefits

The Federal Consolidated Omnibus Budget Reconciliation Act of 1985 requires that the City offer employees, retirees and their families the opportunity to continue group health and/or welfare fund coverage in certain instances where the coverage would otherwise terminate. The monthly premium will be 102% of the group rate (or 150% of the group rate for the 19th through 29th months in cases of total disability, see B.2). All group health benefits, including Optional Riders, are available. The maximum period of coverage is 18, 29, or 36 months, depending on the reason for continuation.

As a result of collective bargaining agreements, Medicare-eligible enrollees and/or their Medicare-eligible dependents are being offered continuation benefits similar to COBRA if a COBRA event should occur (see Medicare-Eligibles, page 46).

1. Eligibility

Employees Not Eligible for Medicare

Employees of the City of New York are eligible for continuation under COBRA if their health and welfare fund coverages are terminated due to a reduction in hours of employment or termination of employment (for reasons other than gross misconduct). For termination due to gross misconduct contact your agency benefits representative for more information. Termination of employment includes unpaid leaves of absence of any kind.

Spouses/Domestic Partners Not Eligible for Medicare

Spouses/Domestic Partners of employees or retirees have the right to choose continuation of coverage if they lose coverage for any of the following reasons: 1) death of the City employee or retiree; 2) termination of the employee's City employment (for reasons other than gross misconduct); 3) loss of health coverage due to a reduction in employee's hours of employment; 4) divorce from the City employee or retiree; 5) termination of domestic partnership with the City employee or retiree; 6) retirement of the employee. (See Retirees below.)

Dependent Children Not Eligible for Medicare

Dependent children of employees or retirees have the right to continue coverage if coverage is lost for any of the following reasons: 1) death of a covered parent (the City employee or retiree); 2) the termination of a covered parent's employment (for reasons other than gross misconduct); 3) loss of health coverage due to the covered parent's reduction in hours of employment; 4) the dependent ceases to be a "dependent child" under the terms of the Health Benefits Program; 5) retirement of the covered parent. (See Retirees below.)

Retirees

If you are not eligible to receive City-paid health care coverage (see Eligibility, page 38) you and your dependents (if not Medicare-eligible) may continue under COBRA the benefits you received as an active employee, for a period of 18 months at 102% of the group cost. If you are eligible for Medicare, see the Medicare-Eligibles section page 46.

If your welfare fund benefits are reduced or eliminated at retirement, you are eligible to continue those benefits that were reduced under the welfare fund as a COBRA enrollee for a period of 18 months at 102% of the cost to the union welfare fund. You should contact your union welfare fund for the premium amounts and benefits available. A list of welfare fund administrators can be obtained from your payroll or personnel office.

NOTE: Individuals covered under another group plan are not eligible for COBRA continuation benefits unless the other group plan contains a pre-existing condition exclusion. However, these people may be able to purchase certain welfare fund benefits. For more information, contact the appropriate fund.

2. Periods of Continuation

Continuation of coverage for the former employee, retiree, family, or individual dependent as a result of termination of employment (for reasons other than gross misconduct), reduction of work schedule, or loss of welfare fund benefits due to retirement is available for a maximum period of 18 months. This period will be measured from the loss of coverage.

If the employee is totally disabled on the date of termination from employment or reduction of hours, continuation of coverage for the employee and eligible dependents may be extended from 18 to 29 months. The monthly premium for the 19th through 29th month will be 150% of the group rate. To qualify for 29 months of COBRA continuation coverage, Social Security must determine that the employee is totally disabled. If Social Security later determines that the individual is no longer totally disabled, COBRA continuation coverage may terminate before the end of the 29th month.

Continuation of coverage for a spouse/domestic partner or dependents as a result of the death, divorce, domestic partner-

ship termination, or loss of coverage due to Medicare-eligibility of the contract holder, or loss of dependent child status, is available for a maximum of 36 months.

Continuation of coverage can never exceed 36 months in total, regardless of the number of events which relate to a loss in coverage. Coverage during the continuation period will terminate if the enrollee fails to make timely premium payments or becomes enrolled in another group health plan (unless the new plan contains a pre-existing condition exclusion).

3. Notification Responsibilities

Under the law, the employee or family member has the responsibility of notifying the City agency payroll or personnel office and the applicable welfare fund within 60 days of the death, divorce, domestic partnership termination, or change of address of an employee, or of a child's losing dependent status. Retirees and/or the family members must notify the Health Benefits Program and the applicable welfare fund within 60 days in the case of death of the retiree or the occurrence of any of the events mentioned above.

Employees who are totally disabled (as determined by Social Security) on the date of termination of employment or reduction of hours must notify their health plan of the disability. The notice must be provided within 60 days of Social Security's determination and before the end of the 18-month continuation period. If Social Security ever determines that the individual is no longer disabled, the former employee must also notify the health plan of this. This notice must be provided within 30 days from Social Security's final determination.

When a qualifying event (such as an employee's death, termination of employment, or reduction in hours) occurs, the employee and family will receive a COBRA information packet from the City agency describing continuation coverage options.

4. Transfer Opportunities

Former employees and dependents who elect COBRA continuation coverage are entitled to the same benefits and rights as employees. Therefore, COBRA enrollees may take part in the annual Transfer Period. Dependents of retirees enrolled in COBRA continuation coverage will continue to receive the same transfer opportunities available to retirees: once-in-a-lifetime transfer (if not already used), and transfer during the normal Transfer Period for retirees.

Individuals eligible for COBRA may also transfer when a change of address allows or eliminates access to a health plan which requires particular Zip Code residency for eligibility.

Application forms to be used during the Transfer Period should be obtained from the COBRA enrollee's current health plan. Applications should be returned to the current health plan which will forward enrollment information to the new plan. Be sure to elect a primary care physician for each family member if selecting an HMO that requires you to do so. **These transfers will become effective on January 1, 1996.**

City agencies do not handle COBRA enrollee transfers, or process any future changes such as adding dependents. All future transactions will be handled by the health plan in which the person eligible for COBRA is enrolled.

5. Election of COBRA Continuation

To elect COBRA continuation of health coverage, the eligible person must complete a "COBRA - Continuation of Coverage Application." Employees and/or eligible family members can obtain application forms from their agency payroll or personnel office. Retirees' eligible family members can obtain application forms by contacting the Health Benefits Program. Please contact the welfare fund if you wish to purchase its benefits.

Eligible persons electing COBRA continuation coverage must do so within 60 days of the date on which they receive notification of their rights, and must pay the initial premium within 45 days of their election. Premium payments will be made on a monthly basis. Payments after the initial payment will have a 30-day grace period.

Medicare-Eligibles

Those employees, retirees, spouses/domestic partners, and dependents who are eligible for Medicare may be eligible to receive continued coverage, similar to COBRA, under the City's Medicare-supplemental plans. Periods of eligibility shall date from the original qualifying event up to 18 months in the case of loss of coverage because of termination of employment or reduction in hours, or up to 36 months in the case of loss of coverage for all other reasons.

If a COBRA qualifying event occurs and you lose coverage, but you and/or your dependents are Medicare-eligible, you may continue coverage by using the COBRA Continuation of Coverage application form. You should indicate your Medicare claim number and effective dates where indicated on the form for Medicare-eligible family members. If you and/or your dependents are about to become eligible for Medicare, and are already continuing coverage under COBRA, inform your health plan of Medicare eligibility for you and/or your dependents at least 30 days prior to date of Medicare eligibility. COBRA-enrolled dependents of the person who becomes Medicare-eligible will be able to continue their COBRA coverage, whether or not the Medicare-eligible person enrolls in the Medicare-Supplemental coverage. The COBRA continuation period for dependents will be unaffected by the decision of the Medicare-eligible employee or retiree.

NOTE: You should contact your health plan for information about other Medicare-Supplemental plans which are offered; some other plans may be better suited to your needs and/or less costly than the plan which is provided under the City's contract.

C. Disability Benefits

If on the date of termination you are totally disabled as a result of an injury or illness, you remain covered with respect to your disability up to a maximum of 18 additional months for the GHI-CBP/EBCBS plan and up to 12 months for the HMO or POS plans. GHI Type C/EBCBS provides only 31 days of additional coverage. This extension of benefits applies only to the disabled person and only covers the disabling condition. Under the GHI plans, if a subscriber is hospitalized at the time of termination, hospital coverage (under Blue Cross) is extended only to the end of the hospitalization. Contact your health plan for details.

CITY COVERAGE FOR MEDICARE-ELIGIBLE RETIREES

(Employees over age 65, see page 48)

When you or one of your dependents becomes eligible for Medicare at age 65 (and thereafter) or through special provisions of the Social Security Act for the Disabled, your first level of health benefits is provided by Medicare. The Health Benefits Program provides a second level of benefits intended to fill certain gaps in Medicare coverage. In order to maintain maximum health benefits, it is essential that you join Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) at your local Social Security Office as soon as you are eligible. If you do not join Medicare, you will lose whatever benefits Medicare would have provided; the City's Health Benefits Program supplements Medicare but does not duplicate benefits available under Medicare. Medicare-eligibles must be enrolled in Medicare Parts A and B in order to be covered by a Medicare HMO plan. The only plan in which Medicare-supplemental benefits are available, regardless of Medicare enrollment, is GHI/EBCBS Senior Care.

A. Medicare Enrollment (Retirees Only)

To enroll in Medicare and assure continuity of benefits upon becoming age 65, contact your Social Security Office during the three-month period before your 65th birthday.

In order not to lose benefits, you must enroll in Medicare during this period even if you will not be receiving a Social Security check.

If you are over 65 or eligible for Medicare due to disability and did not join Medicare, contact your Social Security Office to find out when you may join. If you do not join Medicare Part B when you first become eligible, there is a 10% premium penalty for each year you were eligible but did not enroll. In addition, under certain circumstances there may be up to a fifteen-month delay before your Medicare Part B coverage can begin upon re-enrollment.

If you or your spouse are INELIGIBLE for Medicare Part A although over age 65 (reasons for ineligibility include non-citizenship or non-eligibility for Social Security benefits for Part A), apply to:

N.Y.C. Health Benefits Program
40 Rector Street - 3rd Floor
New York, NY 10006

Coverage for those not eligible for Medicare Part A can be provided under certain health plans. Under this Non-Medicare eligible coverage, you continue to receive the same hospital and/or medical benefits as persons not yet age 65.

If you are living outside the USA or its territories, Medicare benefits are not available. If you do not continue to pay for Medicare Part B however, you will be subject to penalties if you return to the USA and apply late.

Please provide full identifying information, including name, date of birth, address, agency from which retired, pension number, health plan and certificate numbers, health code, Social Security Number and Medicare claim number (if any). Also give the reason for ineligibility for Medicare Part A and/or Part B.

If you are eligible for Medicare Part B as a retiree but neglect to file with the Social Security Office during their enrollment period (January through March) or prior to your 65th birthday, you will receive supplemental medical coverage only, and only through GHI/EBCBS Senior Care.

B. Notification to the Health Benefits Program and Health Plans

You must notify the Health Benefits Program in writing immediately upon receipt of your or your dependent's Medicare card. Include the following information: a copy of the Medicare card and birth dates for yourself and spouse, retirement date, pension number and pension system, name of health plan, and name of union welfare fund. In some cases, the Health Benefits Program or your health plan may contact you requesting some of this information. Once the Health Benefits Program is notified that you are covered by Medicare, deductions from your pension check will be adjusted, if applicable, and you will automatically receive the annual Medicare Part B premium reimbursement (See C., Medicare Premium Reimbursement). The Health Benefits Program will notify your health plan that you are enrolled in Medicare so that your benefits can be adjusted. This may take several months. If your plan does not accept Medicare-eligibles, you will receive special instructions concerning changing to another health plan.

C. Medicare Premium Reimbursement

The City will reimburse you for a portion of the monthly premium for Medicare Part B for yourself and your spouse and dependents enrolled on Medicare disability.

Periodically, the Medicare Part B premium is increased by the Social Security Administration. At the time of each increase, legislation must be approved by the City Council authorizing the City to reimburse you at a new rate. The reimbursement rate for 1994 is $29.00 per month.

If you are receiving a Social Security check, the premium for Medicare Part B will be deducted from that check monthly. If you are not receiving a Social Security check, you will be billed on a quarterly basis by the Social Security Administration. You must be receiving a City pension check and be enrolled as the contract holder for City health benefits in order to receive reimbursement for Part B premiums. For most retirees, the refund is issued automatically by the Health Benefits Program, 40 Rector Street, 3rd Floor, New York, NY 10006, telephone (212) 513-0470. Medicare Part B reimbursement checks are generally issued once a year in the summer following the year in which premiums are paid.

D. Medical Expense Reimbursement

In order to further encourage participation in the Medicare HMO plans, the City and the Municipal Unions are pleased to announce that retirees who are enrolled in any of the Medicare HMO plans will each be entitled to a $200 Medical Expense Reimbursement (to a maximum of $400 per contract if 2 or more Medicare-eligibles are enrolled) from the City if enrolled for a full benefit period of one year, in addition to the current Medicare Reimbursement. The program will begin in October 1995. The first payment will be made in July 1996 and will cover two quarters-October 1, 1995 through March 31, 1996. The retiree must be enrolled in the Medicare HMO plan on July 1, 1996 to qualify for any payment.

Thereafter, retirees and eligible dependents will receive a full payment only if enrolled in an approved plan from April 1st through March 31st of the following year, subject to being enrolled the following July 1.

If a retiree is enrolled on the last day of a quarterly period (March 31st, June 30th, September 30th, December 31st), a payment of $50 will be credited for that quarter. If the retiree is not enrolled on the last day of the quarter, no payment will be provided for that quarter. Payment of the amounts credited for the coverage period (April through March) will occur in July provided the retiree is enrolled in the Medicare HMO plan on July 1.

If you qualify for the Medical Expense Reimbursement because of your enrollment in a Medicare HMO plan, you will be reimbursed automatically. No other action on your part is required.

SPECIAL PROVISIONS FOR MEDICARE-ELIGIBLE EMPLOYEES

Federal law requires the City of New York to offer all employees or their dependents over age 65 or covered by Medicare through the Special Provisions of the Social Security Act for the Disabled* the same health coverage offered to employees not yet age 65 and under the same conditions. Your City health plan will automatically become your primary coverage and Medicare will provide secondary coverage.

If you wish Medicare to be your primary coverage, you are not eligible for the City's group health plan. You must complete the waiver section of the Health Benefits Application (Form ERB 95) and return it to your agency payroll or personnel office.

A. Retirement

At retirement, employees who have chosen Medicare as their primary plan or whose dependents have not been covered on their plan because their spouse/domestic partner elected Medicare as the primary plan may re-enroll in the City health program. This is done by completing a Health Benefits Application (Form ERB 95) and submitting it to their payroll or personnel office.

Also at retirement, employees for whom the City health plan had provided primary coverage for Medicare-eligibles are permitted to change health plans effective on the same date as their retiree health coverage.

B. Medicare Premium Reimbursement

Employees and their dependents covered by Medicare have identical benefits to those provided to employees and their dependents under age 65. Because of the cost of these benefits, the City does not reimburse employees or dependents for their Medicare Part B premiums if the City health plan is primary. (However, where Medicare has been elected as primary coverage, reimbursement of Medicare Part B premiums will be made.)

Medicare premium reimbursement will be available at retirement when Medicare becomes the primary plan.

C. Medicare Enrollment

Medicare Medical Insurance (Part B) is voluntary with a monthly premium which is subject to change. If you and/or your dependents choose City health coverage as primary, Medicare will be supplementary to any City health plan.

There are no penalties for late enrollment in Medicare Part B if employees choose the Health Benefits Program as primary coverage and cancel or delay enrollment in Medicare Part B coverage until retirement or termination of employment, when Medicare enrollment is permitted for a limited period of time. Medicare Hospital Insurance (Part A) should be maintained. For most persons, Part A coverage is free.

COORDINATION OF BENEFITS (COB)

A. General

You may be covered by two or more group health benefit plans, which may provide similar benefits. Should you have services covered by more than one plan, your City health plan will coordinate benefit payments with the other plan. One plan will pay its full benefit as a primary insurer, and the other plan will pay secondary benefits. This prevents duplicate payments and overpayments. In no event shall payments exceed 100% of a charge.

The City program follows certain rules which have been established to determine which plan is primary; these rules apply whether or not you make a claim under both plans.

B. Rules of Coordination

The rules for determining primary and secondary benefits are as follows:

1. The plan covering you as an employee is primary before a plan covering you as a dependent.
2. When two plans cover the same child as a dependent, the child's coverage will be as follows:
   - The plan of the parent whose birthday falls earlier in the year provides primary coverage.
   - If both parents have the same birthday, the plan which has been in effect the longest is primary.
   - If the other plan has a gender rule (stating that the plan covering you as a dependent of a male employee is primary before a plan covering you as a dependent of a female employee), the rule of the other plan will determine which plan will cover the child. (See "C" below for special rules concerning dependents of separated or divorced parents.)
3. If no other criteria apply, the plan covering you the longest is primary. However, the plan covering you as a laid-off or retired employee, or as a dependent of such a person, is secondary, and the plan covering you as an active employee, or as a dependent of such a person, is primary, as long as the other plan has a COB provision similar to this one.

*The rules are somewhat different for persons eligible for Medicare due to end-stage renal disease. Consult your Medicare Handbook or agency health benefits representative for further information.

C. Special Rules for Dependents of Separated or Divorced Parents

If two or more plans cover a dependent child of divorced or separated parents, benefits are to be determined in the following order:

1. The plan of the parent who has custody of the child is primary.
2. If the parent with custody of a dependent child remarries, that parent's plan is primary. The step-parent's plan is secondary and the plan covering the parent without custody is tertiary (third).
3. If the specific decree of the court states one parent is responsible for the health care of the child, the benefits of that parent's plan are determined first. You must provide the appropriate plan with a copy of the portion of the court order showing responsibility for health care expenses of the child.

D. Effect of Primary and Secondary Benefits

1. Benefits under a plan that is primary are calculated as though other coverage did not exist.
2. Benefits under a plan that is secondary will be reduced so that the combined payment or benefit from all plans are not more than the actual charges for the covered service. The plan that is secondary will never pay more than its full benefits.

NO-FAULT EXCLUSION

The Health Benefits Program will not provide benefits for any services for which benefits are available under a No-Fault Automobile Policy.

THE EMPLOYEE BLOOD PROGRAM

Your health plan covers the cost of administering transfusions and pays blood processing fees for employees, retirees and eligible family members. It does not pay for the storage of your own blood for future use.

Blood replacement fees are not covered by any health plan offered by the City. Hospitals in the Greater New York region generally have access to sufficient voluntarily donated blood and therefore do not bill for replacement fees. The Greater New York region comprises New York City, Long Island, nearby counties in upstate New York, and some parts of northern New Jersey. Outside that area, many hospitals are still charging for blood that is not replaced.

To help our community maintain the blood reserves required to avoid resumption of replacement fees, the Employee Blood Program sponsors a voluntary donor program for City employees, called the City Donor Corps. City Donor Corps members who donate once a year are entitled to certain benefits for themselves and family members. For further information, see your agency Blood Program Coordinator.

SECTION FIVE

BASIC PLAN AND OPTIONAL RIDER COSTS

Employees and Non-Medicare Retirees

Basic coverage is available to the subscriber under certain plans at no cost, while other plans require a payroll or pension deduction. A rider for optional benefits may be purchased under all but one of the plans (DC 37 Med-Team/HealthEase does not offer an Optional Rider).

Under the voluntary Medical Spending Conversion (MSC) Program (see page 39), health plan deductions for employees will be made on a pre-tax basis. Employees do have the option of declining this benefit.

Each rider is a package. You may not select individual benefits within the rider package. However, if your union welfare fund provides benefits similar to some or all of those listed in the rider for your plan, those specific benefits will be provided only by your welfare fund and will not be available through the health plan rider. In these cases, payroll and pension deductions will be reduced accordingly.

If your health plan's Optional Rider only consists of a prescription drug plan, and your welfare fund provides this same benefit, you should not choose the rider, because deductions will not be adjusted.

These rates are in effect as of July 1, 1995, and are subject to change.

	COSTS							
	Monthly		Bi-Weekly		Semi-Monthly		Weekly	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family
BLUECHOICE POS								
BASIC PLAN	$35.29	$97.58	$16.24	$44.91	$17.65	$48.79	$8.12	$22.46
OPTIONAL RIDER								
Prescription Drugs	24.32	59.60	11.20	27.44	12.16	29.80	5.60	13.71
TOTAL	$59.61	$157.18	$27.44	$72.35	$29.81	$78.59	$13.72	$36.17
CHOICECARE								
BASIC PLAN	$6.47	$20.37	$2.98	$9.38	$3.24	$10.19	$1.49	$4.69
OPTIONAL RIDER								
Prescription Drugs	14.38	37.40	6.62	17.21	7.19	18.70	3.31	8.61
TOTAL	$20.85	$57.77	$9.60	$26.59	$10.43	$28.89	$4.80	$13.30
CIGNA HEALTHCARE								
BASIC PLAN	$12.76	$63.44	$5.87	$29.20	$6.38	$31.72	$2.94	$14.60
OPTIONAL RIDER								
Prescription Drugs	16.26	43.09	7.49	19.83	8.13	21.55	3.74	9.92
TOTAL	$29.02	$106.53	$13.36	$49.03	$14.51	$53.27	$6.68	$24.52
GHI-CBP/EBCBS								
BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OPTIONAL RIDER								
GHI Prescription Drugs	$21.35	$39.12	$9.83	$18.01	$10.68	$19.56	$4.91	$9.00
EBCBS 365-Day Hospitalization	2.02	4.82	0.93	2.22	1.01	2.41	0.46	1.11
GHI Outpatient Psychiatric Care / Inpatient SubAbuse Treatment	1.15	2.64	0.53	1.22	0.58	1.32	0.26	0.61
Full-time Students to Age 23								
EBCBS Hospital Coverage	-0-	4.23	-0-	1.95	-0-	2.12	-0-	0.97
GHI Medical Coverage	-0-	7.59	-0-	3.49	-0-	3.80	-0-	1.75
GHI Enhanced NYC Non-Par Provider Reimbursement Schedule	5.86	15.82	2.70	7.28	2.93	7.91	1.35	3.64
TOTAL	$30.38	$74.22	$13.99	$34.17	$15.20	$37.12	$6.98	$17.08
GHI TYPE C / EBCBS								
Current Members Only								
BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OPTIONAL RIDER								
GHI Prescription Drugs	$21.35	$39.12	$9.83	$18.01	$10.68	$19.56	$4.91	$9.00
EBCBS 365-Day Hospitalization	8.38	19.98	3.86	9.20	4.19	9.99	1.93	4.60
TOTAL	$29.73	$59.10	$13.69	$27.21	$14.87	$29.55	$6.84	$13.60

	COSTS							
	Monthly		Bi-Weekly		Semi-Monthly		Weekly	
	Individual	Family	Individual	Family	Individual	Family	Individual	Family
HIP / HMO								
BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OPTIONAL RIDER								
Prescription Drugs	$29.02	$71.09	$13.36	$32.72	$14.51	$35.55	$6.68	$16.36
Appliances and Private Duty Nursing	1.50	3.67	0.69	1.69	0.75	1.84	0.35	0.84
TOTAL	$30.52	$74.76	$14.05	$34.41	$15.26	$37.39	$7.03	$17.20
HIP CHOICE PLUS								
BASIC PLAN	$36.80	$90.18	$16.94	$41.51	$18.40	$45.09	$8.47	$20.75
OPTIONAL RIDER								
Prescription Drugs	29.02	71.09	13.36	32.72	14.51	35.55	6.68	16.36
TOTAL	$65.82	$161.27	$30.30	$74.23	$32.91	$80.64	$15.15	$37.11
MED-TEAM / HEALTHEASE								
BASIC PLAN (No Rider Available)	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
METROPLUS								
Formerly Metropolitan Health Plan								
BASIC PLAN	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
OPTIONAL RIDER								
Prescription Drugs	$29.02	$71.09	$13.36	$32.72	$14.51	$35.55	$6.68	$16.36
TOTAL	$29.02	$71.09	$13.36	$32.72	$14.51	$35.55	$6.68	$16.36
PHYSICIANS HEALTH SERVICES								
BASIC PLAN	$29.97	$97.45	$13.79	$44.85	$14.99	$48.73	$6.90	$22.43
OPTIONAL RIDER								
Prescription Drugs	23.62	61.05	10.88	28.10	11.81	30.52	5.43	14.05
TOTAL	$53.59	$158.50	$24.67	$72.95	$26.80	$79.25	$12.33	$36.48
SANUS PLUS								
BASIC PLAN	$12.87	$31.43	$5.92	$14.47	$6.44	$15.72	$2.96	$7.23
OPTIONAL RIDER								
Prescription Drugs	16.31	41.79	7.51	19.23	8.15	20.89	3.76	9.62
TOTAL	$29.18	$73.22	$13.43	$33.70	$14.59	$36.61	$6.72	$16.85
U.S. HEALTHCARE Q.P.O.S.								
BASIC PLAN *	$22.54	$56.20	$10.37	$25.87	$11.27	$28.10	$5.19	$12.93
OPTIONAL RIDER								
Prescription Drugs *	20.60	51.20	9.49	23.56	10.30	25.60	4.74	11.79
TOTAL	$43.14	$107.40	$19.86	$49.43	$21.57	$53.70	$9.93	$24.72
U.S. HEALTHCARE HMO								
BASIC PLAN	-0-	$7.00	-0-	$3.22	-0-	$3.50	-0-	$1.61
OPTIONAL RIDER								
Prescription Drugs *	$20.60	51.20	$9.49	23.56	$10.30	25.60	$4.74	11.79
TOTAL	$20.60	$58.20	$9.49	$26.78	$10.30	$29.10	$4.74	$13.40
WELLCARE OF NEW YORK								
BASIC PLAN	$16.81	$65.92	$7.74	$30.34	$8.41	$32.96	$3.87	$15.17
OPTIONAL RIDER								
Prescription Drugs	15.23	39.58	7.01	18.22	7.61	19.79	3.50	9.11
TOTAL	$32.04	$105.50	$14.75	$48.56	$16.02	$52.75	$7.37	$24.28

* *These rates will become effective January 1, 1996.*

MEDICARE-ELIGIBLE RETIREES AND DEPENDENTS

Retiree contracts in which there is one Medicare-eligible person and one non-Medicare eligible person will be deducted at the combined rate for one Medicare individual plus one non-Medicare individual. No more than two Medicare-eligible individual deductions will be charged regardless of the number of Medicare-eligibles who are included in the retiree's contract.

Medicare HMO Plans - Retirees enrolled in these plans will receive enhanced prescription drug coverage, the cost of which will be deducted from their pension check, if their union welfare fund does not provide prescription drugs or does not provide benefits deemed to be equivalent, as determined by the City of New York, to the prescription drug rider available through their plan.

There is no pension deduction for the following health plans: AvMed, CIGNA, Elderplan, DC 37 Med-Team/HealthEase, and HIP Medicare Advantage.

	Medicare Per Person
BLUE CHOICE	
Basic Plan	–0–
Drug Rider	$ 70.79
Effective 7/1/95 TOTAL	$ 70.79
CHOICECARE Nassau County	
Basic Plan	–0–
* Drug Coverage	$ 31.38
Effective 10/1/95 TOTAL	$ 31.38
CHOICECARE Suffolk & Queens Cos.	
Basic Plan	–0–
Drug Rider	$ 73.23
Effective 7/1/95 TOTAL	$ 73.23
GHI / EBCBS SENIOR CARE	
Basic Plan	–0–
Rider GHI Prescription Drugs	$ 53.39
Rider EBCBS 365-Day Hosp	2.30
Effective 7/1/95 TOTAL	$ 55.69
HIP VIP NY	
Basic Plan	–0–
* Drug Coverage	$ 18.08
Effective 1/1/96 TOTAL	$ 18.08
HIP VIP NJ	
Basic Plan	–0–
* Drug Coverage	$ 31.36
Effective 1/1/96 TOTAL	$ 31.36
OXFORD MEDICARE ADV NJ Only	
Basic Plan	–0–
* Drug Coverage	$ 43.80
Effective 10/1/95 TOTAL	$ 43.80

	Medicare Per Person
PHYSICIANS HEALTH SVCS CT	
Basic Plan	$ 13.03
Drug Rider	56.05
Effective 7/1/95 TOTAL	$ 69.08
PHYSICIANS HEALTH SVCS NY	
Basic Plan	$ 38.03
Drug Rider	56.05
Effective 7/1/95 TOTAL	$ 94.08
SANUS	
Basic Plan	$ 37.47
Drug Rider	66.56
Effective 7/1/95 TOTAL	$ 104.03
US HEALTHCARE HMO NY	
Basic Plan	–0–
* Drug Coverage	$ 25.20
Effective 7/1/95 TOTAL	$ 25.20
US HEALTHCARE HMO NJ	
Basic Plan	–0–
* Drug Coverage	$ 39.90
Effective 7/1/95 TOTAL	$ 39.90
US HEALTHCARE HMO CT	
Basic Plan	–0–
* Drug Coverage	$ 28.60
Effective 7/1/95 TOTAL	$ 28.60
US HEALTHCARE HMO DEL	
Basic Plan	–0–
* Drug Coverage	$ 43.80
Effective 7/1/95 TOTAL	$ 43.80

	Medicare Per Person
US HEALTHCARE HMO MD	
Basic Plan	–0–
* Drug Coverage	$ 26.90
Effective 7/1/95 TOTAL	$ 26.90
US HEALTHCARE HMO MASS	
Basic Plan	–0–
* Drug Coverage	$ 39.00
Effective 7/1/95 TOTAL	$ 39.00
US HEALTHCARE HMO NH	
Basic Plan	–0–
* Drug Coverage	$ 29.20
Effective 7/1/95 TOTAL	$ 29.20
US HEALTHCARE HMO Pgh,PA	
Basic Plan	–0–
* Drug Coverage	$ 22.00
Effective 7/1/95 TOTAL	$ 22.00
US HEALTHCARE HMO Phila,PA	
Basic Plan	–0–
* Drug Coverage	$ 21.80
Effective 7/1/95 TOTAL	$ 21.80
WELLCARE of NEW YORK	
Basic Plan	$ 28.71
Drug Coverage	In Basic
Effective 7/1/95 TOTAL	$ 28.71

	Medicare		
	Indiv or Fam Contract	Family Split Contract (a.i. means ' at least ')	
	ALL Persons On Medicare	a.i. One Medicare and One Non-Medicare	a.i. One Medicare and a.i. Two Non-Medicare
BCBS HEALTH OPTIONS So. FLA			
Basic Plan	–0–	$ 55.22	$ 115.42
* Drug Coverage	–0–	17.32	40.75
Effective 7/1/95 TOTAL	–0–	$ 72.54	$ 156.17
CAC-UNITED H'CARE So. FLA			
Basic Plan	–0–	–0–	–0–
* Drug Coverage	–0–	$ 7.80	$ 20.68
Effective 7/1/95 TOTAL	–0–	$ 7.80	$ 20.68
PCA QUALICARE So. FLA			
Basic Plan	–0–	$ 14.36	$ 100.26
* Drug Coverage	–0–	28.71	79.83
Effective 7/1/95 TOTAL	–0–	$ 43.07	$ 180.09

* *Medicare HMO Plans*

Notes

Notes

Standard Forms, Inc.
276 Park Ave. South
New York, NY 10010